

White Paper

The Cost of 340B to People with Diabetes

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Abstract

The 340B Drug Pricing Program (“340B program”) contributes to higher drug spending by displacing negotiated rebates that are used to lower net drug prices. In addition, a patient’s out-of-pocket costs for a drug may exceed the 340B provider’s acquisition price, a difference we call a 340B upcharge. These effects are of particular concern for the 29 million U.S. adults who have been diagnosed with diabetes and who have healthcare expenditures that are more than double those of adults without the disease.

This study estimates lost rebates and 340B upcharges among commercially insured individuals with diabetes. Estimates are based on national samples of drug purchasing data, prescription claims data, public 340B participation data for hospitals and clinics, and claim-level 340B eligibility estimates.

We estimate that in 2025, commercial health plans incurred \$4.8 billion in additional drug spending attributable to lost negotiated rebates from covered individuals living with diabetes while these same individuals paid an estimated \$156 million in

340B upcharges. Together, these costs represent approximately 37% of the total lost negotiated rebates and 340B upcharges among all commercially insured individuals, more than four times their expected share given that approximately 8.5% of U.S. adults have been diagnosed with diabetes.

We also estimate that 340B hospitals and clinics generated \$7.1 billion in 340B spread revenue from commercially insured individuals with diabetes and their health plans in 2025. The \$4.8 billion in displaced rebates represents over two-thirds of that estimated spread revenue, suggesting that a substantial share of 340B revenue is being funded by higher costs in the commercial market.

Conclusion: Commercially insured people with diabetes and their health plans bear a disproportionate share of 340B-related costs through direct out-of-pocket upcharges and displaced negotiated rebates. These findings suggest that 340B-related costs may be especially concentrated among patients with chronic, high-cost conditions and the employers and plans that finance their care.



Introduction

Diabetes is a common chronic condition affecting tens of millions of individuals in the U.S. Approximately three-quarters of people with diabetes have received an official diabetes diagnosis, representing about 29 million U.S. adults, or 8.5% of the adult population.^{1,2} Diabetes is associated with multiple comorbidities, with the majority of patients exhibiting two or more chronic conditions such as cardiovascular disease, cancer, chronic kidney disease, arthritis, depression, dementia, musculoskeletal disorders, and various infections.^{3,4} As a consequence, healthcare costs for individuals diagnosed with diabetes are 2.6 times higher than for those without the disease, with annual costs of almost \$20,000 per individual,¹ of which about \$6,400 is attributable to prescription drugs.⁵

The 340B Drug Pricing Program (340B program) is a large and rapidly growing federal program in which participating hospitals and clinics are able to purchase qualifying drugs at heavily discounted, Medicaid-like prices and sell them to payers and patients at full market rates. 340B providers can use the difference between reimbursement and acquisition cost to generate 340B spread revenue through arbitrage. The program was designed to reduce drug prices for 340B clinics and hospitals so they can expand access to free and discounted care for safety net patients most in need.⁶ In 2025, 340B purchases at list prices were estimated to be \$180 billion to \$200 billion and grew 20% year over year.⁷

Multiple studies have found that the 340B program raises healthcare costs for employers, workers, and taxpayers, including through provider consolidation,⁸ and higher drug utilization.⁹ Additionally, commercial insurers typically do not receive rebates on drugs that were purchased at the 340B price (displaced negotiated rebates).^{10,11} The greater the volume of drugs utilized, the larger the value of negotiated rebates that is lost. Thus, when people with chronic conditions are patients of 340B hospitals and clinics, they can end up bearing disproportionately high 340B costs.

This study quantifies the cost of the 340B program to commercially insured individuals who have diabetes and to their health plans. Specifically, we combine national samples of drug purchases and prescriptions with publicly available 340B participation data to estimate both patient out-of-pocket upcharges and negotiated drug rebates displaced by 340B discounts. Out-of-pocket upcharges capture the immediate financial burden patients face when filling prescriptions, a burden that can be especially salient for people with diabetes, who in many cases rely on ongoing drug therapy to survive. We then compare these costs with the corresponding estimates for commercially insured individuals in general, irrespective of their diabetes status.



Data and methods

Data

This study uses several IQVIA proprietary data sources: the Longitudinal Access and Adjudication Dataset (LAAD) for pharmacy claims, the DDD subnational sales database, and claim-level 340B eligibility scores. LAAD is a national sample of pharmacy claims that includes patient cost sharing, plan, and payer information. DDD captures wholesaler sell-in to pharmacies, hospitals, and clinics, with drug sales valued using both Wholesale Acquisition Cost (WAC) and estimated 340B acquisition price. 340B eligibility scores estimate the likelihood that a prescription is 340B eligible by integrating 340B provider and contract pharmacy participation data with physician affiliation data. A detailed methodological description of the analysis is provided below.

Methods

DETERMINATION OF SCOPE

We identify all commercial patients with at least one paid diabetes-related claim, defined as any branded drug in the IQVIA Uniform System of Classification (USC) level-3 category of diabetes or the Medi-Span Generic Product Identifier (GPI) level-2 category of antidiabetics.^{12,13} In 2025, we extract all paid claims for this cohort over the full year, across all products. We use claim-level 340B eligibility estimates to measure the likelihood that a claim is 340B eligible. For each claim, we append pricing inputs from DDD, including WAC and 340B acquisition price, providing a consistent basis for measuring both patient cost exposure and rebate displacement. The scope is designed to capture all claims, not just diabetes-specific prescriptions, to understand how 340B-related costs may accumulate for patients with diabetes.

340B OUT-OF-POCKET UPCHARGE

We quantify 340B out-of-pocket upcharges for branded drugs by comparing observed patient out-of-pocket costs with estimated 340B acquisition prices. At the claim level, the upcharge is defined as the amount by which a patient’s out-of-pocket cost, including deductible, copay, or coinsurance, exceeds the 340B acquisition price for the dispensed drug. Each claim-level upcharge is weighted by the claim’s 340B eligibility to account for uncertainty about whether the claim was filled using 340B drugs. The weighted upcharges are then aggregated across all claims for each patient to estimate annual patient-level out-of-pocket upcharges for 2025. Figure 1 provides an illustrative claim-level example.

COMMERCIAL REBATES LOST TO 340B

We estimate commercial rebates displaced by 340B for branded drugs by first constructing the rebate amount that would have been expected in the absence of 340B. At the claim level, expected rebate displacement is calculated as the negotiated rebate amount multiplied by the claim’s 340B eligibility score. These expected values are then aggregated across claims to create patient-level and cohort-level estimates for commercially insured diabetes patients. For comparison, we repeat the same calculation for all commercially insured patients, regardless of diabetes status, to produce an overall benchmark for 340B-related rebate displacement.

Figure 1: Claim-level example of the 340B out-of-pocket upcharge for a person with diabetes. OOP: out-of-pocket

CLAIM	BRAND	LIST PRICE	340B PRICE	PATIENT OOP COST	UPCHARGE IF 340B	340B ELIGIBILITY	EXPECTED UPCHARGE
1	X	\$1000	\$600	\$1000	\$400	50%	\$200
2	Y	\$500	\$200	\$200	\$0	20%	\$0
3	Z	\$200	\$20	\$50	\$30	100%	\$30

Limitations

This study has several limitations:

Our estimates of the cost of 340B to patients with diabetes are likely conservative for several reasons. First, our analysis is restricted to self-administered drugs, since the reimbursement data necessary to study physician-administered drugs were not immediately available. Second, our analysis focuses on costs borne by commercially insured patients with diabetes and their health plans and does not quantify costs incurred by Medicare or Medicaid beneficiaries. Nevertheless, the same mechanisms exist in Medicare and Medicaid. Medicare beneficiaries with diabetes may experience 340B-related out-of-pocket upcharges, while the use of 340B drugs can displace manufacturer rebates in Medicare Part D and managed Medicaid.

Findings

340B out-of-pocket upcharges

In 2025, approximately 10 million commercially insured patients with diabetes had at least one paid branded claim, totaling 92 million branded claims across all products, including therapies unrelated to diabetes. Based on claim-level 340B eligibility scores, an estimated 12% of these claims were 340B eligible. Among those 340B claims, 18% had patient out-of-pocket costs that exceeded the 340B acquisition price, resulting in a 340B upcharge. Across all diabetes patients, estimated 340B upcharges totaled \$156 million in 2025, or approximately 38% of the \$414 million in total upcharges incurred by all commercially insured patients.

Figure 2: Estimated 340B out-of-pocket upcharges among commercially insured patients with diabetes, by claim and patient exposure, 2025

SCOPE (BROAD TO NARROW)	DESCRIPTION
All diabetes patients’ branded paid claims in 2025	In 2025, 10 million diabetes patients had at least one paid branded claim, totaling 92M claims across all products
340B claims	About 12% of branded paid claims from diabetes patients were 340B eligible
340B claims with 340B upcharge	18% of the 340B claims had upcharges, totaling \$156M in 2025
Average annual 340B upcharge per patient with high exposure	\$822 per patient and \$35M in total upcharges

At the claim level, the average 340B upcharge was \$14 across all 340B claims, representing a mixture of claims with no upcharge, including post-deductible claims where flat copays are more often experienced, and claims with an upcharge. Among the 18% of claims with an upcharge, the average was \$73, based on an average 340B price of \$448 per dispensed claim.

At the patient level, diabetes patients with high 340B exposure, defined as 12 or more branded-drug claims with 340B upcharges in 2025, had an average annual upcharge of \$822 per patient. Although they

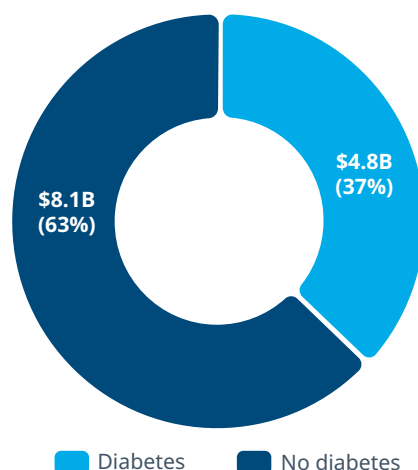
represented only 0.4% of the patient population in scope, these patients accounted for \$35 million in total upcharges, or about 23% of all 340B upcharges among commercially insured diabetes patients.

Patients without high exposure may have had fewer claims with upcharges, fewer branded-drug claims overall, or a mix of 340B-eligible and non-340B-eligible claims during the year possibly depending upon where they filled their prescription. Their annual 340B out-of-pocket upcharges would therefore be expected to be lower, reflecting less observed 340B exposure.

Commercial rebates displaced by 340B

In 2025, commercially insured diabetes patients were associated with an estimated \$4.8 billion in commercial rebates displaced by 340B discounts. Across all commercially insured patients, total 340B-related rebate displacement was \$12.8 billion.¹⁴ Diabetes patients accounted for over 37% of this total, even though they represented approximately 8.5% of patients in the analyzed commercial population (Figure 3).

Figure 3: Distribution of 340B-related commercial rebate displacement among commercially insured patients, by diabetes status



Viewed relative to total drug spending, the \$4.8 billion in displaced rebates represented 5.3% of the \$90.3 billion in WAC-based drug utilization among commercially insured diabetes patients in 2025.

Discussion

Multiple studies have reported that the 340B program increases drug costs by displacing the negotiated rebates used by health plans to lower the net cost of branded drugs. Our study suggests that these 340B-related costs are not evenly distributed across commercially insured individuals. A disproportionate share of both patient upcharges and displaced rebates is borne by people with diabetes who are particularly exposed because diabetes is a chronic condition that is already associated with high drug and healthcare utilization. As a result, diabetes patients and their health plans bear costs associated with the 340B program through both direct out-of-pocket upcharges and higher net drug spending.

The concentration of lost rebates among diabetes patients may have important implications for employer-sponsored insurance. Approximately 159 million Americans receive coverage through employer-sponsored plans, and 65% of covered workers are enrolled in self-insured plans,¹⁵ meaning lost rebates can directly affect employer budgets. Diabetes also imposes substantial costs on working-age, employer-insured populations through both medical spending and productivity losses among employees with diabetes.¹⁶ Because diabetes prevalence rises with age and diabetes patients incur substantially higher healthcare costs than the general population, 340B-related rebate losses may further increase costs in this population. At the margin, higher expected healthcare costs may influence compensation and benefit design.^{17,18}

The relationship between lost rebates and 340B spread revenue also warrants consideration. In this study, diabetes patients were associated with approximately \$4.8 billion in displaced commercial rebates and an estimated \$7.1 billion in 340B spread revenue. Provider-side spread revenue exceeded plan-side rebate losses by roughly 50%. This pattern is consistent with the economics of the 340B program: commercial rebates generally offset only part of drug costs, while the 340B discount usually creates larger spread revenue when reimbursement remains at list price. As a result, rebate displacement represents only one component of a broader transfer of value from commercial payers and other stakeholders to 340B providers and their business partners.

More broadly, our findings highlight an often-overlooked consequence of 340B: the erosion of negotiated rebates that health plans use to reduce net prescription drug spending. When a claim is filled with a 340B-discounted drug, the rebate that would otherwise lower the drug's net cost is unavailable. Prior research¹⁹ found that growth in 340B activity was associated with higher employer-sponsored insurance premiums, estimating that 340B expansion accounted for approximately 8% of premium growth between 2017 and 2023. These findings are consistent with the mechanism identified in this study: costs reduced through 340B discounts are shifted elsewhere in the healthcare system. Applying the 37% share of lost rebates attributable to diabetes, as estimated in this study, suggests that the cost of 340B tied to diabetes patients may account for approximately 3% of premium growth.

Health plans have limited options when faced with higher net drug spending. Additional costs must eventually be absorbed through higher premiums, greater cost sharing, reduced access, or lower margins. Whether borne directly by self-funded employers or indirectly through premium increases, the financial burden is ultimately redistributed across employers, workers, and beneficiaries. For workers with diabetes, these financing decisions occur against a broader

backdrop of workplace protections and accommodations intended to prevent discrimination and preserve access to employment.²⁰

The consequences of higher healthcare costs extend beyond healthcare financing. Employer-sponsored insurance is part of total compensation, meaning healthcare spending competes directly with wages. Existing labor economics literature has linked rising health insurance costs to slower wage growth, reduced employment, fewer hours worked, and greater earnings inequality.^{17,21,22,23} These effects may be particularly important for younger and lower-wage workers, for whom benefit costs represent a larger share of compensation. Consequently, the costs associated with 340B rebate displacement extend beyond diabetes patients and their health plans, affecting all workers through higher premium contributions, slower wage growth, or reduced employment opportunities.

These findings show that 340B creates significant distributional tradeoffs. Covered entities generate financial value from the program, while patients and health plans absorb costs through out-of-pocket upcharges and lost rebates. In this study, diabetes patients paid direct 340B upcharges, and their health plans lost billions of dollars in rebates. Although program advocates argue that 340B revenue supports hospitals' safety-net missions, recent investigations by the Minnesota Department of Health and the U.S. Senate,^{24,25} along with estimates of 340B middlemen fees,²⁶ show that 340B revenue flows are complex and may not translate directly into patient assistance or safety-net care. Evaluating the program therefore requires tracing both where 340B revenue comes from and how it is used.

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