White Paper

Do 340B Rebates Create a Significant Financial Burden for 340B Providers?

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Table of contents

Abstract

In 2025, the Health Resources and Services Administration (HRSA) proposed transitioning the 340B Drug Pricing Program ("340B program") to a rebate model. While 340B hospitals and others expressed concerns, some patient advocates and covered entity types already using a rebate model expressed support. A court enjoined (prohibited via an injunction) the pilot after crediting 340B provider trade association representations that purchasing drugs at list price and receiving a 340B rebate at a later date would impose a severe financial burden on them.

We decided to examine the claims made in the litigation. Significantly, 5 of the 10 drugs that would have been subject to the 340B rebate pilot subsequently reduced their list prices, potentially reducing interest costs associated with the use of 340B rebates. This data-driven study evaluates whether a rebate-based purchasing model would impose a meaningful financial burden on 340B providers. We divide covered entities into three groups based on financial liquidity and assumed short-term borrowing rates. Interest costs are estimated overall and per covered entity for the 10 drugs subject to Maximum Fair Price (MFP) in 2026.

Using January 2026 list prices for the 10 MFP drugs, estimated annual interest costs per covered entity ranged from $590 for federal grantees to $23,649 for Disproportionate Share (DSH) hospitals, versus estimated purchases of $86,294 and $6.9 million, respectively. These interest costs represent less than 1% of combined 340B purchases for these drugs at list prices.

Consistent with, and extending, our earlier study of 340B rebate cash flow, these findings indicate that interest costs under a 340B rebate model are marginal and inconsistent with claims that a rebate model would impose a significant financial burden on 340B providers.

Introduction

On January 1, 2026, two important federal drug pricing policies — Maximum Fair Price (MFP) and the proposed 340B rebate pilot — were scheduled to go into effect involving the same set of 10 drugs. However, while MFP rebates were implemented, the 340B rebate pilot was not. Although HRSA first announced a 340B rebate pilot on August 1, 2025,[1] and approved it on October 30, 2025,[2] the 340B rebate model was the subject of a legal challenge brought by the American Hospital Association (AHA) and others and enjoined by the United States District Court for the District of Vermont on the eve of the January 1, 2026 implementation date.[3]

In their complaint to block the 340B rebate model, the plaintiffs highlighted their contention that requiring them to pay a commercial price for a drug and then secure a rebate payment would "inflict hundreds of millions of dollars" of costs on hospitals and other 340B providers.[3] The complaint described those costs as "crushing", "enormous", "and calamitous",[4] but plaintiffs provided no data to support these allegations.

A group of trade association amici curiae ("friends of the court") filed a brief in support of the plaintiffs' position. Citing an earlier survey of a non-randomized group of approximately 3% of all covered entities, the brief asserted that the average "float" cost to a 340B hospital would be $8.6 million a year.[5] The results of the survey stated that the average annual float cost for an individual DSH hospital would be $72.2 million.[6]

In enjoining the 340B rebate model, the district court adopted the arguments made by plaintiffs and amici. The court referred to the "floating costs" associated with a 340B rebate model, which it defined as the costs involved in paying "full price" for a drug and then awaiting a rebate payment. It credited the contention that these costs would involve "hundreds of millions of dollars" and cited the "economic impact" of the proposal as a key basis for the injunction.[3]

Many parties, including the court, have asserted that, under a 340B rebate model, the provider orders drug inventory, pays for it, and only thereafter receives a rebate payment, generating negative cash flow and, therefore, interest costs. This depiction contends that when inventory is ordered and when payment to the wholesaler is due are essentially concurrent. In practice, however, there is typically a lag between the two events, with timing between the point at which the product is delivered and paid for determined by a set of contractual provisions known as "payment terms". Depending on these terms, receipt of the rebate may precede, coincide with, or follow payment for the drug.

To estimate the true interest cost of 340B rebates, we previously created a data-driven cash flow model[7] based on a set of parameters including the drug's wholesale acquisition cost (WAC, also known as list price), its 340B discount price, and its reimbursed price, wholesaler payment terms, short-term borrowing rates, and the timing of the 340B rebate payment. Contrary to the assertions made in the district court litigation, we found that interest costs were small, typically less than 1% of the drug's list price, and were the same or less for the 340B rebate model than for existing drug inventory models that use upfront discounts to effectuate the 340B discount.

After completion of our prior study and following the trial court's decision to enjoin the 340B rebate model pilot, 5 of the 10 MFP drugs lowered their list prices. Because some stakeholders have based their claims about the harm they say will follow from a 340B rebate model on the "float" between an initial acquisition price and the rebated 340B price, reductions in list price should be considered in assessing the cash flow impacts attributed to the rebate model. We also refine our cash flow model by breaking out 340B providers into three groups — DSH hospitals, non-DSH hospitals, and federal grantees — based on short-term borrowing rates and to help determine whether there may be different impacts to different groups of 340B providers.

List price decreases

As of January 2026, list prices have been reduced for 5 of the 10 drugs subject to MFP in 2026: Eliquis, Fiasp, Farxiga, Imbruvica, and Jardiance. Manufacturers appear to have reduced list prices for MFP drugs to mitigate exposure to overlapping inflation penalties and duplicate discounts. Under the IRA, Medicare inflation rebates apply when the price of MFP drugs rises faster than inflation, while Medicaid inflation penalties, which are embedded in the calculation of the 340B ceiling price, create additional liability for manufacturers. Although the IRA prohibits duplicate 340B discounts and inflation rebates for Part D, there is no reliable way of identifying 340B drugs in pharmacy claims, because the 340B status of self-administered drugs is typically unknown when drugs are dispensed to the patient.

The interaction of MFP discounts, Medicaid best price, and Medicare and Medicaid inflation rebates create multiple pathways for duplicate payments affecting multiple programs.

The reduction in list prices directly limits the acquisition prices that critics of the rebate model assert are a source of "float" costs. Our model reflects the impact of these lower list prices on a 340B rebate mechanism.

Payment terms

The payment terms governing drug purchases by hospitals and clinics from wholesalers are not generally publicly available. In our original cash flow study of 340B rebates,[7] we used a parameter for payment terms that was based on stakeholder interviews supplemented by a number of published reports. Consistent with that information, we applied a "30 day pay", and supplemented this with a sensitivity analysis to consider shorter payment terms as low as zero days. Our results, even at zero days, showed that interest costs associated with a 340B rebate model were small.

After our study was published, we received anecdotal information that some 340B providers often use shorter payment terms, from 7 to 14 days, in addition to other providers using up to 30 days. The largest and best resourced of the three categories we separately consider are DSH hospitals.[8] Non-DSH hospitals can vary from entities as large and well-resourced as a DSH hospital to smaller, less well-resourced entities.[8] Given this variation, we apply a conservative parameter for the borrowing rate of these non-DSH hospitals, using a rate that stakeholders acknowledged was appropriate. Federal grantees tend to be smaller and less resourced than non-DSH hospitals[9] and, accordingly, we apply an even higher borrowing rate for these entities, which stakeholders again stated was appropriate for them.

Data and methods

Data

We use a refined version of the cash flow model described in our original study,[7] dividing 340B providers into three groups — DSH hospitals, non-DSH hospitals, and federal grantees — to capture differences in financial liquidity and short-term borrowing rates for drug purchases. We apply rates that are the lowest (most favorable) for DSH hospitals at 6%, the highest for grantees at 12%, and 9% at non-DSH hospitals, reflecting differences in creditworthiness and publicly available information about their access to short-term financing,[10,11] as confirmed by stakeholder interviews. These are representative rates that reflect differences across entity types.

We apply a wholesaler payment term parameter of 10.5 days for all three provider groups, which is the average of the 7-14 day range industry stakeholders told us is typically offered to most 340B providers.

Inventory turnover is the average number of days that drugs "sit on the shelf" before they are dispensed to patients. A slower or faster turnover may increase or decrease the impact on a purchaser's cash flow of having to carry the cost of a drug before it is dispensed and reimbursed. For the high-volume, branded products selected for price negotiation and MFP, we applied an average turnover of two weeks, which was supported by stakeholder input we received.

The 340B sales we used are based on IQVIA's DDD subnational sales database. DDD captures wholesaler sell-in data to all customer types including pharmacies, hospitals, clinics, and Long-Term Care (LTC) facilities, and spans all drug types including branded products and generics, biologics and biosimilars, and self-administered and physician-administered drugs.

To determine per-entity costs, we estimate the number of covered entities using records in the Office of Pharmacy Affairs Information System (OPAIS).[12] For hospital-type covered entities, including both DSH and non-DSH hospitals, which may have hundreds of child sites associated with each parent, we count parent entities only, since financial and borrowing decisions for hospitals are typically made at the parent level of the organization. For federal grantees, we count each separately registered entity.

Methods

The analysis focuses on interest costs associated with potential temporary negative cash balances caused by the timing of rebate payments.

Annual 340B sales were estimated using 2025 data for the 10 drugs subject to MFP in 2026, which we updated using January 2026 list prices. Sales were allocated across the three groups of 340B providers using ratios based on covered entity purchases reported by HRSA for 2024.[13]

Per-entity interest costs were estimated by dividing total interest costs in each group of 340B providers by the number of covered entities in each such category. Interest costs are expressed either as a percentage of sales or in dollars.

A drug's "float" is the difference between its acquisition cost under a 340B rebate model and its acquisition cost under current 340B drug inventory models, which is the difference between its list price and its 340B price. For commercial prescriptions, this is the 340B spread revenue for the drug.

Our cash flow models include the factors summarized in Figure 1, such as drug acquisition cost, the 340B discount, drug utilization, wholesaler payment terms (the lag between the drug being ordered and the payment to the wholesaler), inventory turnover, short-term borrowing rates, payment of the 340B rebate, and payer reimbursement. Day 0 was defined as the day the drug was dispensed.

Figure 1. Factors impacting interest costs for 340B drugs. CE: covered entity.

FACTOR	COSTS HIGHER FOR:	CASH FLOW MODEL ASSUMPTION
Acquisition cost of drug	Higher priced drugs	January 2026 list price
340B discount for drug	Higher 340B discounts	January 2026 340B discount
Drug utilization	Higher utilization	2025 covered entity purchases
Wholesaler payment terms	Shorter payment terms	7-14 days
Inventory turnover	Slower turnover	15 days
Short-term borrowing rates	Higher rates	6-12% depending on CE type
Payment of 340B rebate	Slower payment	10 days after 340B claim approved
Payer reimbursement	Slower reimbursement	30 days after drug dispensed

Limitations

Our estimates may overstate interest costs associated with a 340B rebate model. Specifically, we assume that wholesaler payment terms for all 340B providers fall into a 7-14 day range, represented by an average of 10.5 days, although some providers acknowledge they use longer payment terms. Also, due to a lack of available data, we are unable to model concessions such as prompt payment discounts, which can lower effective acquisition costs below WAC. We ignore interest income from positive cash balances, which occur when 340B rebate payments are received within the window of payment terms. Finally, to the extent that pharmacies limit dispensing of MFP drugs following the introduction of that reduced reimbursement metric, our findings would overstate the interest costs of acquiring those drugs under a 340B rebate model.

Our study does not attempt to estimate potential operational costs associated with the 340B rebate model.

Findings

We present results first in aggregate and then on a per-entity level basis to differentiate total program impact versus organization-level impact. Using January 2026 WAC prices and the cash flow assumptions described in Figure 1, we estimate aggregate interest costs 340B providers would incur under a rebate-based purchasing model for the 10 drugs subject to MFP in 2026. For all covered entity types, combined annual interest costs are estimated to be $53.7 million, representing 0.40% of the $13.4 billion in combined 340B purchases at WAC for these drugs.

INTEREST COSTS BY COVERED ENTITY TYPE

Interest costs vary to some extent across covered entity segments, reflecting differences in purchasing volume, short-term borrowing rates, and financial liquidity (Figure 2).

DSH hospitals account for the majority of estimated interest costs, with $36.0 million annually, or 67% of total program-wide interest costs. This reflects the dominant role of DSH hospitals in the 340B program, where

they account for 79% of total 340B purchases at 340B prices, combined with their lower short-term borrowing rates versus other entity types. Interest costs for DSH hospitals represent only 0.34% of their estimated $10.5 billion in annual purchases of the 10 MFP drugs.

Non-DSH hospitals incur an estimated $5.5 million in annual interest costs versus $1.1 billion in purchases at WAC, which represents 0.51% of purchase value. Estimated annual interest costs for federal grantees are $12.1 million versus $1.8 billion in purchases, which is 0.68% of purchases.

Figure 2. Annual interest costs for 340B providers for the 10 drugs subject to MFP in 2026. Drug prices are based on January 2026 list prices.

ENTITY TYPE	INTEREST COSTS	PURCHASES	% COSTS
DSH	$36,041,798	$10,548,531,173	0.34%
Non-DSH	$5,520,556	$1,077,152,224	0.51%
Grantees	$12,089,240	$1,769,108,762	0.68%
Total	**$53,651,593**	**$13,394,792,158**	**0.40%**

PER-ENTITY INTEREST COSTS

Because financing decisions are typically made and their impact experienced at the organizational level, we also examine interest costs on a per-entity basis. To perform this analysis, we estimated the number of covered entities in each group as described in Methods above. We estimate that, on average, annual interest costs under a rebate model will be $23,649 for DSH hospitals, $3,004 for non-DSH hospitals, and $590 for federal grantees, as summarized in Figure 3. Costs as a percentage of purchases are the same as reported in Figure 2.

Figure 3. Annual interest costs per 340B provider for the 10 drugs subject to MFP in 2026. Drug prices are based on January 2026 list prices. CE: covered entity.

ENTITY TYPE	# CES	INTEREST COSTS	PURCHASES
DSH	1,524	$23,649	$6,921,608
Non-DSH	1,838	$3,004	$586,046
Grantees	20,501	$590	$86,294

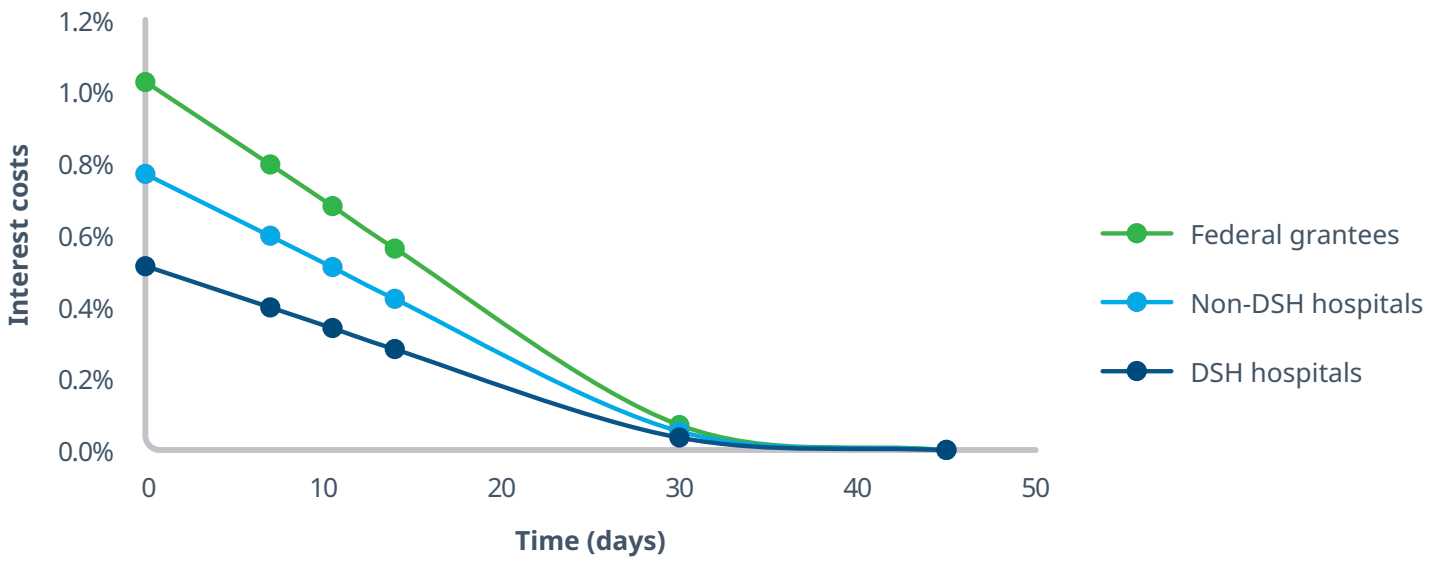
SENSITIVITY TO WHOLESALER PAYMENT TERMS

Interest costs under a rebate model are sensitive to wholesaler payment terms, defined as the period between the inventory order and the payment due date. Shorter payment terms may increase interest costs by potentially requiring covered entities to pay wholesalers before the 340B rebate payment is received, creating a temporary negative cash flow that must be financed using short-term borrowing. To quantify these effects, we conducted sensitivity analyses for each of the three groups of 340B providers.

For our baseline scenario that reflects drug payment terms of 10.5 days, interest costs range from 0.34% of the list price of purchases for DSH hospitals to 0.68% for federal grantees. As payment terms become shorter, interest costs increase, reaching a maximum for a 0-day payment term of 0.51% for DSH hospitals, 0.77% for non-DSH hospitals, and 1.03% for federal grantees, as shown in Figure 4.

Conversely, extending payment terms may further reduce interest costs. For example, at 30-day payment terms, interest costs fall to 0.04% for DSH hospitals, 0.05% for non-DSH hospitals, and 0.07% for federal grantees. For payment terms longer than 30 days, interest costs approach zero because both the rebate payment and the payer reimbursement arrive before the wholesaler payment is due.

Figure 4. Sensitivity analysis for interest costs versus wholesaler payment time.



Discussion

In litigation surrounding the 340B rebate model, it has been asserted that "the greatest drawback for healthcare providers is the significant financial burden of providing up-front payments at commercial prices".[14] Furthermore, the 340B rebate pilot that was scheduled to begin January 1, 2026 was halted by the district court based on its giving credence to the contention that a rebate model would cost covered entities "hundreds of millions of dollars". As was predicted by our group and others, however, multiple MFP drugs selected for the pilot lowered their list prices.

Using these lower prices and a multi-factorial cash flow analysis, we find no evidence to support the notion that 340B rebate interest costs are "substantial" or in any way consistent with either the aggregate or the per-entity estimates presented by 340B litigants. We find that annual interest costs will range from $590 for federal grantees to $23,649 for DSH hospitals on a per-entity basis, as compared to annual purchases at list price of the 10 MFP drugs of $86,294 and $6,921,608 for federal grantees and DSH hospitals, respectively. Thus, interest costs represent from 0.34% to 0.68% of purchases, and represent a small fraction of routine pharmacy working capital. Because the magnitude of any financing costs depends directly on list prices, these findings underscore the importance of evaluating cash flow impacts under actual pricing conditions rather than using non-randomized surveys completed by interested stakeholders.

Where the litigants in the injunction case represented to the court that a rebate model would "inflict hundreds of millions of dollars" of costs on hospitals and other 340B covered entities[4] and the court credited that figure in its decision, our analysis, which likely overstates the impact of the interest costs involved, identifies total costs across covered entities of $53.7 million. That figure is well below the $100 million threshold for what is considered an "economically significant" rule.

Amici in the litigation represented to the court that the average cost to a 340B hospital of having to "float" purchases under a 340B rebate model would be $8.6 million. Here, the float is the difference between the drug's list price and its rebated 340B price. In comparison, we find the average cost for a 340B hospital, depending on its sub-categorization, will be either $3,004 or $23,649. Based on our analysis, the estimates presented to the court were at least 363 times larger than those arising from our model, even though our model likely overstates the interest costs.

Given that critics have asserted the use of rebates would require 340B hospitals to incur a drug's float as a "cost",[6] it is unsurprising that their cost estimates for a rebate model are inflated. A drug's float is not a measure of cost. It is merely one of a handful of factors including the timing of payments to the wholesaler (i.e., payment terms), the time lags associated with receipt of the 340B rebate and payer reimbursement, and short-term borrowing rates which determine interest costs.

In addition, cash flow, interest costs, and the floating of upfront drug costs are described by rebate critics as though they are somehow unique to the 340B rebate model. In reality, whenever providers purchase drugs in or outside the 340B program, whether using existing drug inventory models or 340B rebates, cash flow may temporarily become negative and interest costs may be incurred. This is inherently the case because drug reimbursement typically lags drug inventory orders.

Sensitivity analyses indicate that interest costs are influenced by wholesaler payment terms. Shortening payment terms to 0 days (payment upon delivery) would increase costs, but extending them beyond the 10.5 day parameter that we applied would reduce them. These costs, under our sensitivity analysis, remain marginal, however, and this is true even though we did not model the concessions paid by wholesalers to their customers that are often associated with shorter payment terms, due to a lack of available data. We note that HRSA's

recent Request for Information for 340B rebate models solicits this information from covered entities, demonstrating the agency's focus on this important question.[15] Were this data to be made available, they could be incorporated into future studies.

We do not attempt to measure operational costs or system integration costs, which were other arguments that the litigants made in opposing the 340B rebate model. We did not examine these asserted costs because we do not believe that it is correct to view them as costs attributable solely or even substantially to the 340B rebate model. HRSA has long required covered entities to collect and maintain the data that would be required under a 340B rebate. Two federal courts of appeals have permitted manufacturers to impose data submission requirements in connection with contract pharmacy transactions, without any connection to a 340B rebate model, and thousands of pharmacies have already developed systems and undertaken submissions under those policies. Furthermore, manufacturers have now instituted data submission requirements for all 340B drug transactions — again without any connection to a 340B rebate model.

Given ongoing federal drug price-control efforts, including but not limited to MFP, Most Favored Nation (MFN) initiatives, and the Federal Trade Commission's recent settlement with pharmacy benefit managers, additional reductions in drug list prices are plausible, even likely. This would further reduce interest costs associated with rebate-based purchasing methods.

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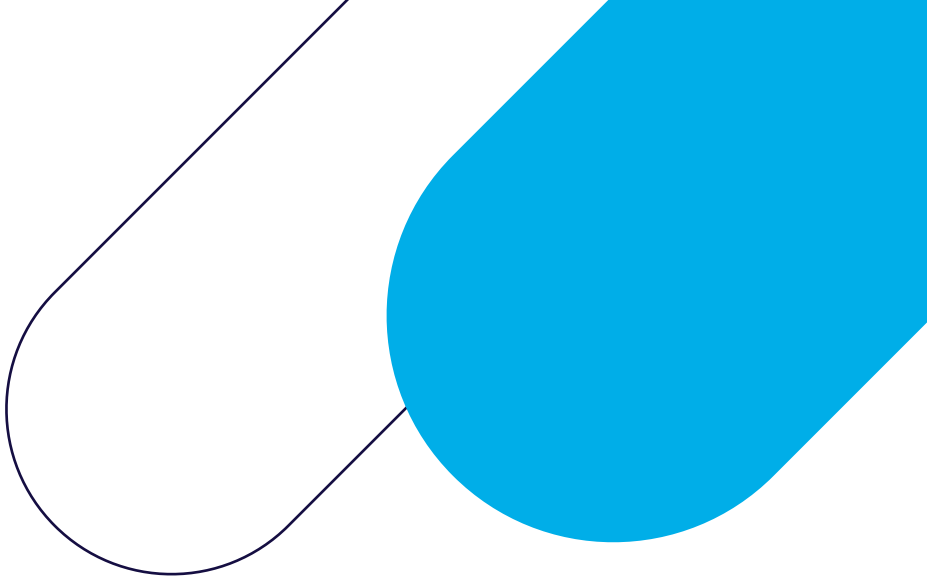
Conflicts of interest

William Sarraille is a board member at Kalderos, Inc., which offers a rebate model solution. He was not compensated for his work on this publication from any source, and Kalderos did not review this publication or have any editorial control over this publication.



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