White Paper

The Size and Growth of the 340B Program in 2025

Estimated 340B purchases totaled $180-$200 billion at list prices

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Abstract

This study is part of an ongoing series by IQVIA that examines the size and growth of the 340B drug pricing program, and provides a descriptive estimate of the size, growth, and composition of the program.

In 2025, 340B purchases reached $179.5 billion at list prices, growing 20.3% year-over-year. From 2018 to 2025, 340B purchases at list prices more than tripled in size and grew at three times the rate of the rest of the U.S. drug market. Adjusted for missing sales in our sample, we estimate that total program purchases at list prices were approximately $200 billion, which is approaching the size of medicare Part D.

The hospital and clinic channels now account for almost three quarters of 340B purchases; and five disease areas — targeted oncology, immunology, anti-virals, diabetes, and anti-arthritics — account for more than two thirds of program sales.

The future growth of the 340B program may be influenced by additional states enacting contract pharmacy mandates and ambiguity in how some 340B providers interpret patient eligibility rules. In addition, policy factors will likely slow program growth, including maximum fair price effects and the possible introduction of a 340B rebate model which would increase transparency for the patient definition and reduce duplicate discounts.

Introduction

The 340B drug pricing program ("340B program") is a federal program in which drugmakers provide substantial, medicaid-like discounts on qualifying drugs to participating hospitals and clinics. The program was designed so that 340B providers would use 340B revenue to help vulnerable individuals access drugs and healthcare.

The substantial and sustained growth of the program in recent years has led to an intense debate about growth drivers, and whether growth is being driven by increased utilization or drug price increases. A recent study published by our group[1] found that 80% of growth in program purchases at list price is due to increased utilization, while only 20% is due to drug price increases. Provider-driven factors that increase utilization include ongoing provider consolidation due to practice acquisition,[2] growth of contract pharmacy networks including the establishment of in-house specialty pharmacies, a higher propensity for 340B providers to treat patients using drugs versus their non-340B peers (with no observed change to one-year mortality or survival duration in the studied population[3]), and ambiguity in how some covered entities interpret patient eligibility rules.[4]

Program growth has also been driven by policy changes, including 340B providers being able to use an unlimited number of contract pharmacies, and the introduction by the Affordable Care Act of new types of covered entities and Medicaid expansion, as described previously.[5]

The current study provides an estimate of the 340B program's size and growth for 2025, including breakouts by distribution channel and disease area.

Findings

In 2025, 340B purchases at list prices reached $179.5 billion, as shown in Figure 1. From January 2018 through December 2025, 340B purchases grew 232.8%, versus 71.3% for non-340B purchases, as shown in Figure 2, meaning that drug purchases through the program grew at more than three times the rate of the rest of the U.S. drug market over this period.

Figure 1. Annual growth of the 340B program, from 2018 to 2025, at list prices

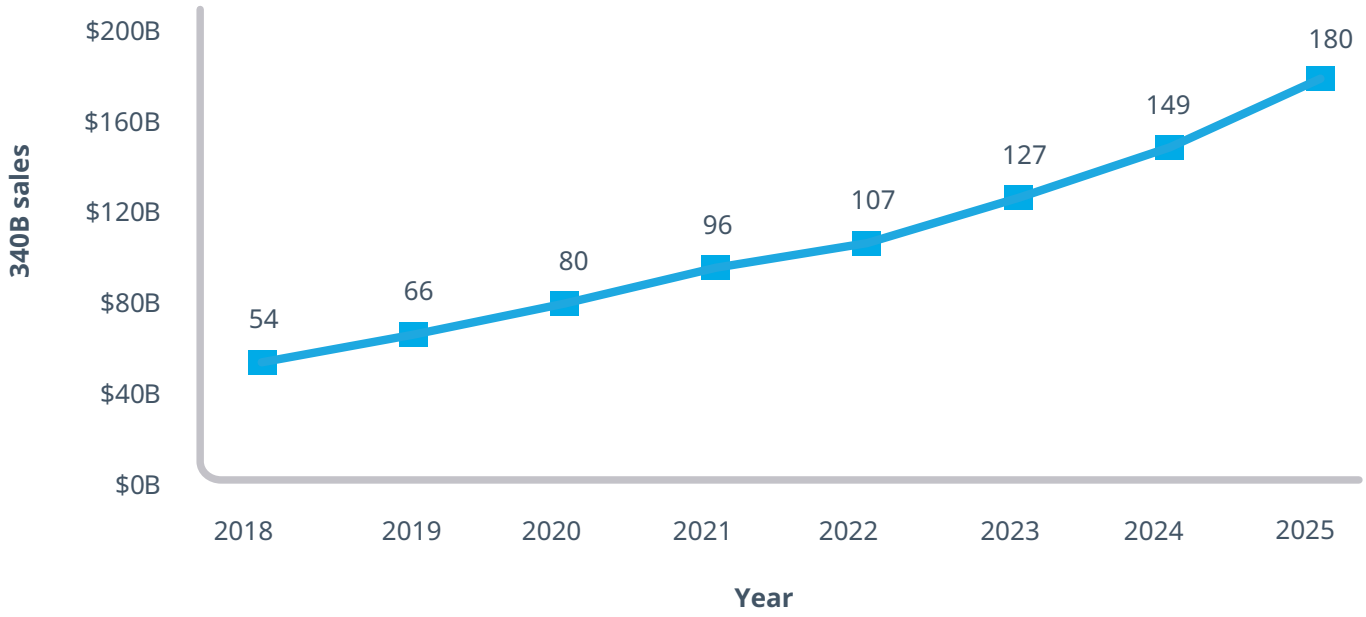
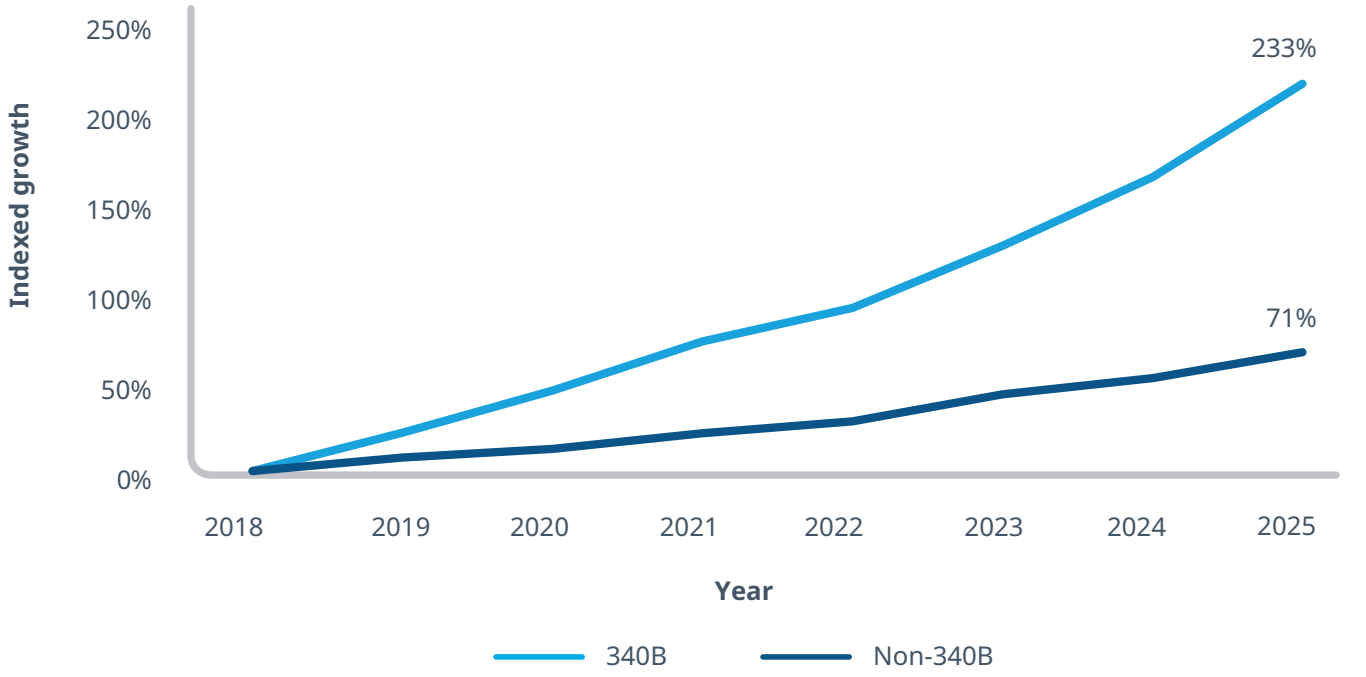


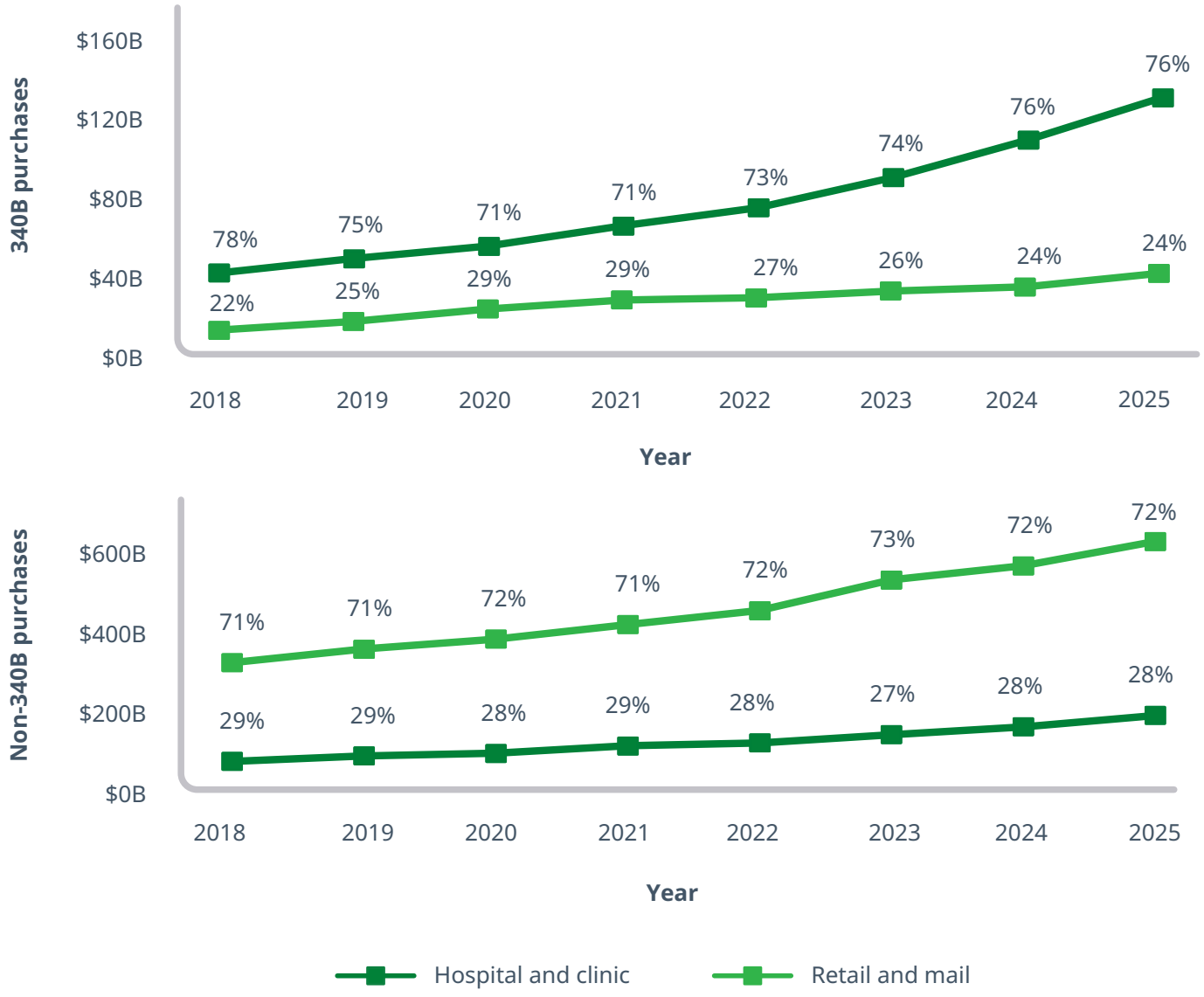
Figure 2. Cumulative year-over-year growth for 340B and non-340B purchases at list price, indexed to 2018



Channel trends

In 2025, almost three quarters of 340B purchases were in the hospital and clinic channels, representing self-administered drugs dispensed at hospital and clinic outpatient pharmacies as well as physician-administered drugs delivered at hospitals. Sales through the hospital and clinic channels were $133 billion. 340B providers also use contracted retail and mail pharmacies to dispense 340B drugs to their patients, including national pharmacy chains, independent pharmacies, and mail order pharmacies. 340B sales through the retail and mail channels were $41 billion. Conversely, for non-340B drugs, only 28% of purchases involved the hospital and clinic channels. These findings highlight the extent to which 340B purchasing is concentrated in provider-controlled dispensing and administration settings, in contrast to the broader U.S. drug market. A breakout by distribution channel is shown in Figure 3.

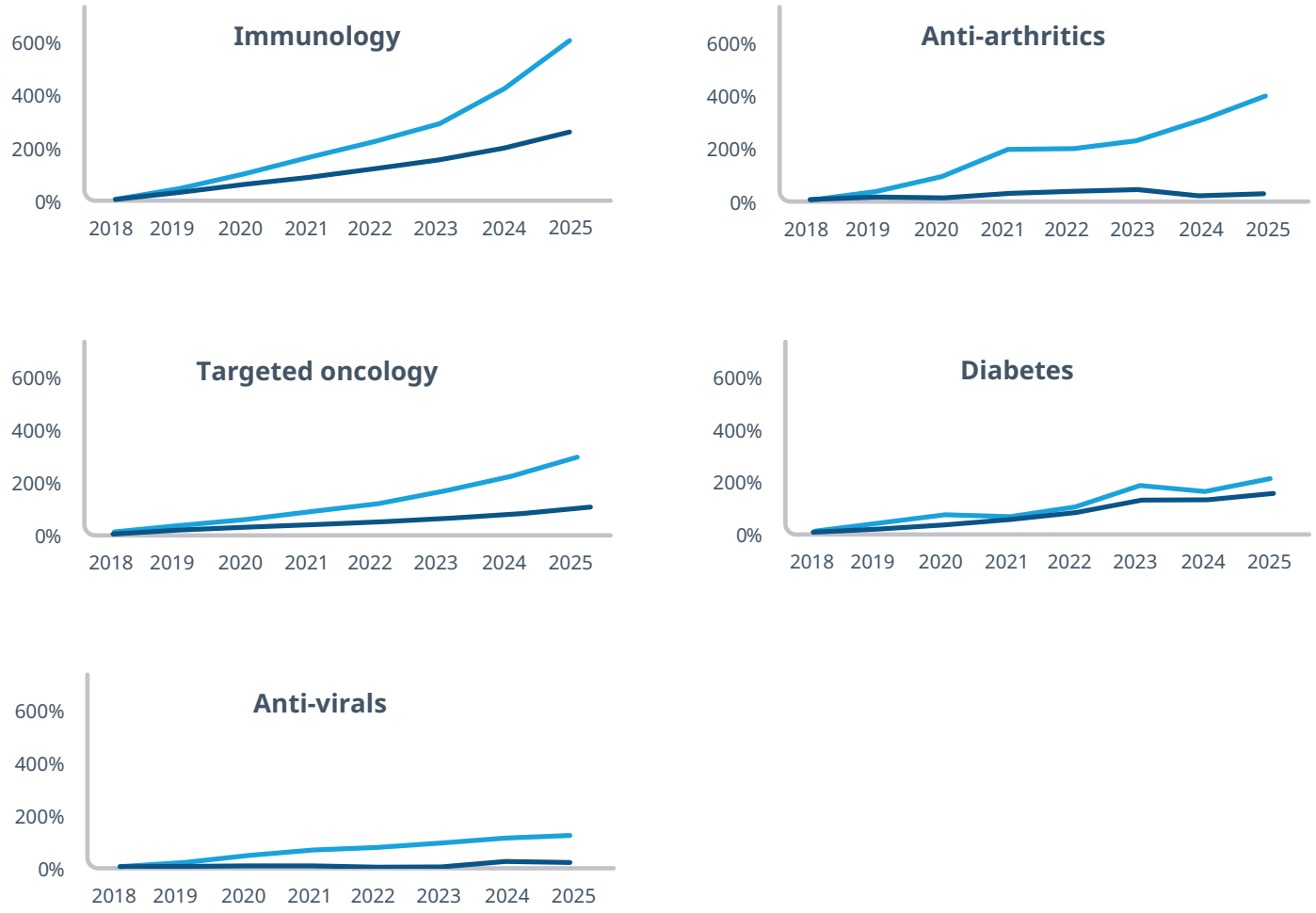
Figure 3.Purchases by distribution channel at list prices for 340B drugs (upper graphic) and non-340B drugs (lower graphic). Labels above the trend lines are the percentage of purchases



Disease areas

Five disease areas accounted for 67.6% of 340B purchases at list prices, which were, in descending order, targeted oncology, immunology, anti-virals, diabetes, and anti-arthritics. Cumulative growth of 340B and non-340B purchases in these five disease areas indexed to 2018 is shown in figure 4. Over this period immunology drugs had the highest indexed growth of 645.3% for 340B purchases, versus 273.6% for non-340B purchases, illustrating the rapid growth of this segment during this time. The concentration of 340B growth in immunology, anti-arthritics, and oncology reflects the growing role of specialty medicines in driving program expansion.

Figure 4. Indexed growth for the five disease areas with the highest 340B purchases at list prices in 2025. Light blue: 340B purchases. Dark blue: non-340B purchases



Discussion

In 2025, 21 states enacted contract pharmacy mandate policies, requiring drugmakers to honor 340B pricing when 340B-eligible drugs are dispensed using contract pharmacies, bringing the total number of states with such mandates to 32. Also, 340B purchases at list price in 2025 grew 20.3%, the highest rate observed since 2020, the year before the majority of manufacturers' contract pharmacy policies were implemented. This suggests that contract pharmacy mandates may be increasing program growth. If this is associated with increased volume, then since 340B discounts displace negotiated rebates,[6,7] the financial burden of these costs, which is borne by employers, state and local governments, Medicare, managed Medicaid, and workers, would also increase.

Although the subnational sales data used for this study is a national sample, it does not capture 100% of drug sales, and we did not attempt to project the sample size to 100%. We estimate that the total size of the 340B program in 2025 is approximately $200 billion, after accounting for incomplete capture in subnational data.

The future growth trajectory of the 340B program is uncertain and will be influenced by multiple factors. For example, eight states have introduced but not yet fully passed bills that mandate the use of contract pharmacies, which, if implemented, would likely grow the program by tens of billions of dollars. Also, ongoing litigation and regulatory ambiguity regarding the 340B patient definition continue to create incentives for 340B providers to invent their own patient eligibility rules,[8] which may be increasing the program's size.

Conversely, a handful of factors may slow program growth. For example, on January 1, 2026, the first 10 drugs subject to price negotiation began reimbursing dispensing entities at Maximum Fair Price (MFP). Furthermore, 5 of these 10 drugs substantially decreased their list prices, which will, after a two-quarter lag, likely decrease their Medicaid inflation rebates, and thus decrease the size of their 340B discounts. These changes will erode both 340B purchases at list price and 340B spread revenue for these drugs, although they will not address duplicate discount concerns.

Another factor that may slow program growth is the use of a 340B rebate model. The rebate model pilot program that was supposed to begin on January 1, 2026 was enjoined by the courts in December 2025, and at the time of publication, a new pilot program has not been announced. Although any future implementation would depend on regulatory design, judicial review, and manufacturer participation, a 340B rebate model would likely prevent 340B providers from making up their own rules for patient eligibility. These factors are summarized in Figure 5.

Figure 5. Summary of factors impacting the future growth of the 340B program

FACTOR	LIKELY EFFECT	WHY IT MATTERS
Contract pharmacy mandates	Growth driver	Removes manufacturer-initiated program integrity policies
Patient definition ambiguity	Growth driver	Expands potential 340B utilization
Hospital consolidation	Growth driver	Shifts utilization to sites of care controlled by 340B providers
MFP implementation	Growth moderator	Reduces 340B spread revenue for MFP drugs dispensed to Medicare Part D patients
Loss of exclusivity	Growth moderator	Reduces branded sales as volume shifts to generics or biosimilars
340B rebate model	Growth moderator	Enforcement (patient definition, duplicate discounts, etc.) at the point of payment

Data sources

Purchasing (sales) data were sourced from IQVIA's DDD subnational sales database from 2018 to 2025. Data included all disease areas, specialty and non-specialty products, branded drugs and generics, prescription and over-the-counter products, and all distribution channels. Purchases were expressed using list pricing (wholesale acquisition cost) at the product/pack level, while growth statistics were calculated as year-over-year percentage changes for the calendar year using dollarized sales.

Estimates of the size of the U.S. pharmaceutical market reported in this report may differ versus those reported elsewhere in the literature. For example, purchases dollarized by using list price do not reflect the impact of manufacturer rebates nor the impact of 340B discounts. Also, sell-in was used to estimate purchases in the mail distribution channel, and the data in DDD was not projected, meaning we did not try to adjust it to represent 100% of the U.S. drug market.

Following the Uniform System of Classification (USC) system,[9] drugs were grouped into disease areas. USC2 groupings were used in this analysis and they define approximately 70 therapeutic categories. This includes diabetes drugs, targeted oncology drugs (e.g., growth factor inhibitors, immune checkpoint inhibitors, CDK inhibitors, and tyrosine kinase inhibitors), immunologic agents (e.g., monoclonal antibodies and glutarimide derivatives), anti-arthritics (including biologics for Crohn's disease, inflammatory bowel disease, psoriasis, and rheumatoid arthritis), anti-virals (e.g., drugs for HIV and HEP-C), respiratory therapy (drugs for asthma and COPD), hemostatic agents (such as heparins and anti-coagulants), psychotherapeutics (antipsychotics, anti-depressants, and ADHD products), neurological agents (drugs for Parkinson's disease, epilepsy, Alzheimer's disease, and migraine), and gastrointestinal agents (infused biologics and proton pump inhibitors).

Distribution channels are retail (chain pharmacies, independent pharmacies, food stores, and mass merchandizers), mail/specialty mail, hospitals, and clinics. Three additional channels — long-term care, miscellaneous and plans, which together represent about 2% of 340B sales — were omitted from channel breakouts. "Hospitals" includes outpatient departments, clinics, and pharmacies owned by a hospital, plus 340B clinics and clinic-owned pharmacies; and "clinics" refers to groups of physicians located at the same address and includes non-hospital 340B clinics. Contract pharmacy 340B volume is contained in the retail and mail channels.

Limitations

Several limitations apply to this study. First, although we used a national sample of sales for the U.S. drug market, capture is not 100% and we did not attempt to compensate for this. Also, the study was limited to a descriptive estimate of program size, growth, and composition. It did not analyze which factors are driving program growth nor their relative importance, the program's cost, or its value to patients.

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About the authors

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Rory specializes in applying real-world data to healthcare analytics and health policy analysis. Over the past five years, he has published more than 20 studies of the 340B program, including its cost to employers and workers, its benefits to patients, the potential impact of 340B eligibility expansion on program size, and the estimated 340B revenue flowing to for-profit stakeholders. 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) and has authored several analytics texts.

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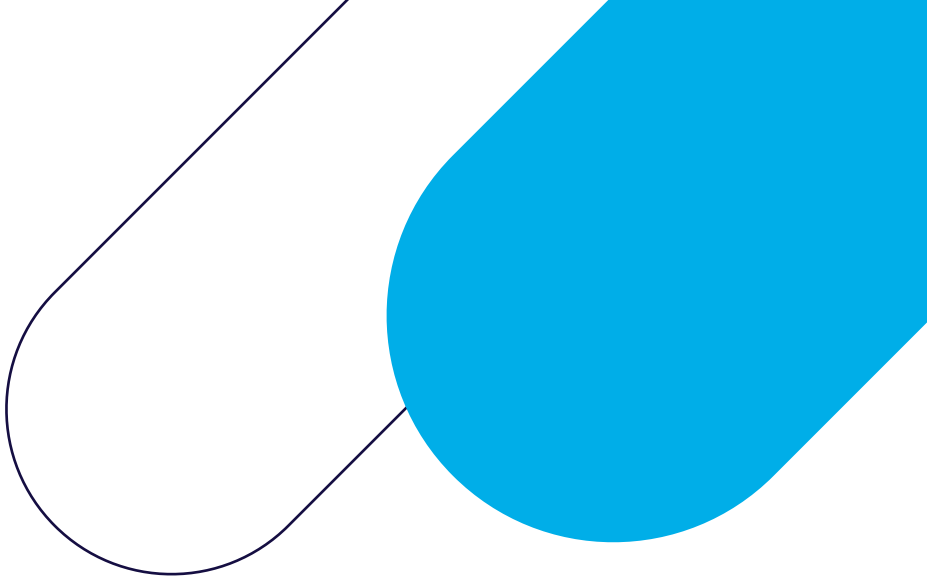

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