POLICY BRIEF

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COMMUNITY ACCESS NATIONAL NETWORK

STATE 340B MANDATES DO NOT IMPROVE PATIENT ACCESS OR AFFORDABILITY

Kalvin Pugh, 340B Policy Director

tiicann.org

Executive Summary

In the United States, high deductibles, cost sharing, and coverage restrictions have led to access barriers for patients seeking essential medications.

The 340B Drug Pricing Program is a federal initiative that mandates manufacturers to sell medicines to certain hospitals and clinics at a significant discount with the legal intent to "reach more eligible patients and provide more comprehensive services." However, this program has become a revenue source for margin-driven entities and their for-profit agents.

Recently, many states have enacted legislation, under the auspices of improving patient affordability, to expand the program in favor of large, tax-exempt hospitals and clinics, as well as their for-profit agents. This brief presents data indicating that state-level laws have only benefited these parties; the laws have not improved access or made medications more affordable for patients.

Background

High deductibles and patient cost sharing as well as coverage restrictions across the United States are creating significant barriers to patients accessing life-changing therapies. In 2023 alone, 98 million new therapy prescriptions were abandoned, and a 2024 study revealed that HIV Pre-exposure Prophylaxis (PrEP) abandonment rates increased dramatically from 5.5% when patients paid $0 out of pocket to 42.6% when costs exceeded $500. These statistics highlight a growing crisis in medication affordability and access.

While the 340B Drug Pricing Program is often a focus of health care policy discussions, only recently has its role in escalating health care costs received significant attention. Enacted in 1992, the 340B Program was designed to enable safety net hospitals and clinics to purchase medicines from manufacturers at steep discounts, intending to improve patient access to affordable medications.

However, the program has evolved considerably from its original intent. Today, 340B functions primarily as a revenue stream for over half of all hospitals in the United States. These hospitals claim substantial discounts on medications while continuing to bill patients and insurers at full price. The profit generated from this "spread" creates perverse incentives that, according to a report and testimony from the Congressional Budget Office (CBO), increase health care costs for patients, payers, and the government alike.

Data Overview

The data reveals troubling patterns: 340B Disproportionate Share Hospitals (DSH) charge more for outpatient medicines than non-340B hospitals and are more frequently associated with greater market consolidation. Paradoxically, these 340B hospitals often provide less charity care than their non-340B counterparts, raising questions about whether the program is fulfilling its intended mission.

Despite these concerns, state legislative efforts have largely avoided patient-centered 340B reforms or transparency measures. Instead, the most common 340B state-level laws consist of mandates requiring manufacturers to provide 340B pricing not only for prescriptions dispensed or administered at participating hospitals and clinics (known as 340B covered entities), but also for those filled at any pharmacy with which a covered entity has established a written contract. Few states have adopted transparency and accountability requirements alongside these expansions.

Combined with non-binding federal contract pharmacy guidance, 340B expansion has resulted in more than 200,000 contract pharmacy arrangements across the United States, with more than 80% involving large chain pharmacies often affiliated with vertically integrated pharmacy benefit managers (PBMs) and insurers.

In fact, Minnesota's first annual 340B transparency report found that 16% of gross 340B revenue went to pharmacies or related third-party administrators, highlighting how the program's benefits are increasingly captured by intermediaries rather than patients.

Research by IQVIA examined the patient experience in the following states to determine how these laws truly impact patients:

- Arkansas
- Louisiana
- Maryland
- Minnesota
- Missouri
- Mississippi
- West Virginia

Patient Populations

cash payers	*medicare*	*commercially insured*
Smallest payer share nationwide.	**Second highest payer share.**	**Greatest payer share; lowest out of pocket patient cost.**
Typically low-income, uninsured, or "underinsured"* *See *Confounders (p.6)*	**People 65 and older, with complex or chronic health conditions, or with disabilities. Their prescription drug coverage has been subject to several recent changes due to the Inflation Reduction Act.**	**Trends in OOP expenses occur in one-year cycles due to deductibles resetting.**

Tracking the Patient Experience

- **Patient Out Of Pocket (OOP) Cost**
  - How much are patients paying at the pharmacy counter?
- **Patient Abandonment Rates**
  - What share of patients are not picking up their prescriptions?

Assessing the following retail and specialty therapeutic areas for evaluation:

- Medicare, the commercial market, and cash pay were included (branded products only).
- Therapeutic areas have been classified as specialty or retail markets based on most recent clinical classifications and product launches.
- Therapeutics areas with large safety net populations were prioritized.

RETAIL	SPECIALTY
Asthma / COPD, Non-insulin Anti-Diabetics, Anti-coagulants	HIV, HCV, Multiple Sclerosis, Oncology

Key Findings

This research seeks to identify the impact state-level mandates for contract pharmacies are having on patient out-of-pocket costs to determine if these laws are directly helping patients ***or instead are primarily expanding a revenue source for hospitals and for-profit partners.***

By analyzing the ***average*** **out-of-pocket costs and abandonment rates** among the first seven states to implement a contract pharmacy mandate,

the data have not consistently shown any enhancement of patient access.

Contract pharmacy mandates have not consistently improved patient affordability or reduced abandonment across channels and therapeutic areas:

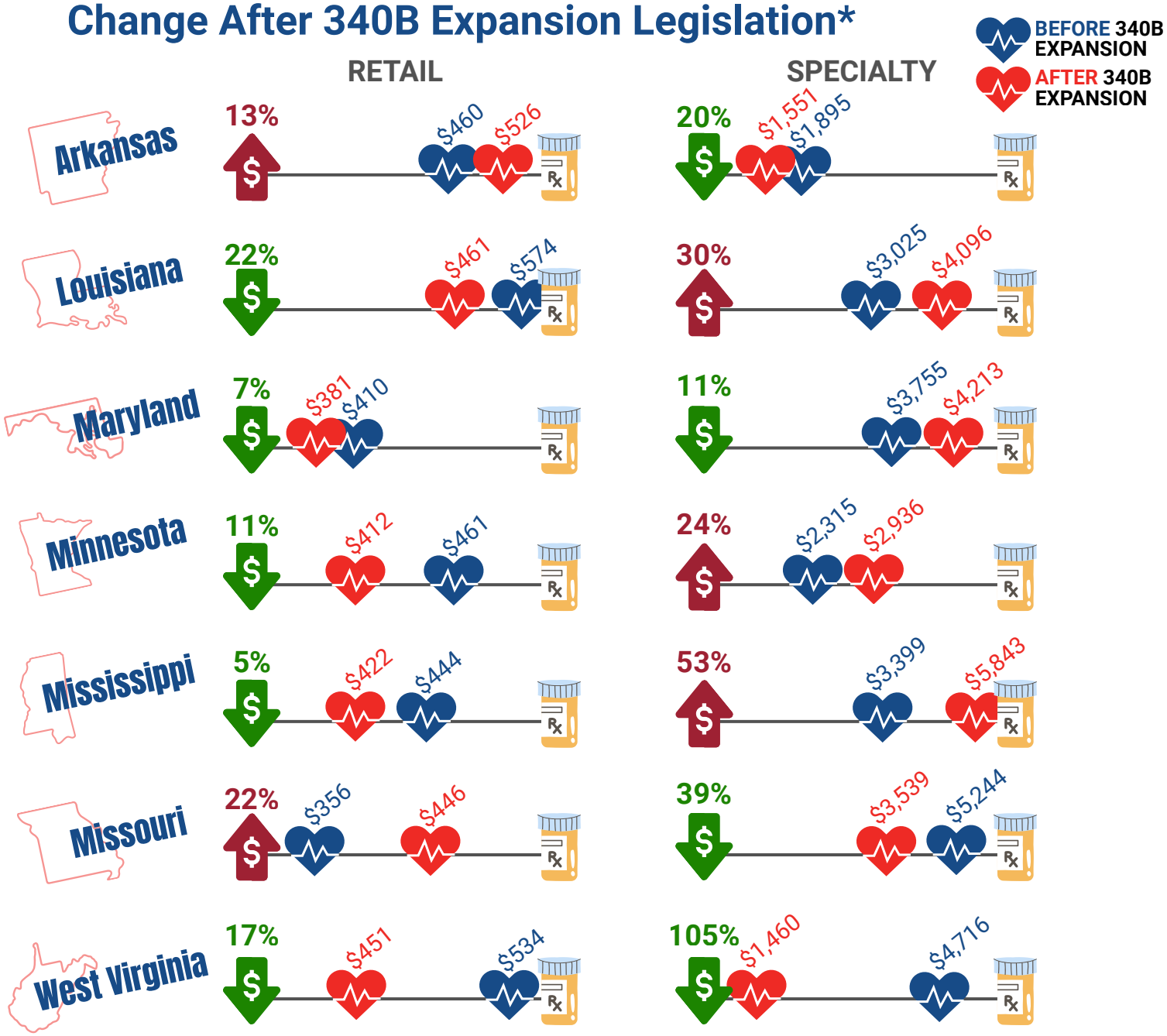
- Across the seven states that enacted contract pharmacy mandates, there is no consistent evidence of reduced patient out-of-pocket costs or abandonment following legislation across all channels and therapeutic areas.
- Controlling for 340B exposure and patient social vulnerability across states and within states did not further highlight any positive impact from the legislation on patient affordability.

Other factors beyond the contract pharmacy legislations may be driving any trends that are observed:

- Trends in retail cash final out-of-pocket costs are consistent pre- and post-contract pharmacy laws and may be attributed to outside factors, including changes in wholesale acquisition cost (WAC) and patient selection bias.
- Cyclical cost spikes in commercial OOP costs are likely driven by deductible resets at the beginning of the year.

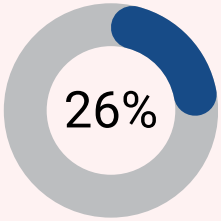
To view the overall data set, click here.

Patient Out-of-Pocket Costs Did Not Meaningfully Change After 340B Expansion Legislation*

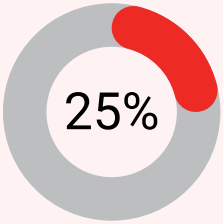


** Data compares OOP costs from Q2 before 340B expansion legislation and Q2 after 340B expansion legislation; across cash payers, commercially insured & Medicare beneficiaries*

Abandonment Rates Did Not Meaningfully Change After 340B Expansion Legislation**



OF PATIENTS ABANDONED MEDICINES AT THE PHARMACY BEFORE LEGISLATION



OF PATIENTS ABANDONED MEDICINES AT THE PHARMACY AFTER LEGISLATION

*** Data compares patient abandonment rates from Q4 before 340B expansion legislation and Q4 after 340B expansion legislation*

Confounders

- "Cash pay" patient-consumers may or may not be insured. Insured patient-consumers opting for "cash pay" models may be experiencing a lack of affordability due to high deductibles, formulary placement, and/or high cost sharing thresholds, or otherwise find greater affordability by way of manufacturer patient assistance programs or cash pay discounts. Thus "cash pay" should not be read as "uninsured" only.

- Certain aspects of the Affordable Care Act (ACA), including 340B expansion, have led to accelerated consolidation and explosive growth in 340B entities. This growth has compelled insurers to acquire pharmacy benefit managers (PBMs), pharmacies, and physician practices, thereby redirecting profits to less regulated business segments. (Joel C. White)

- As the ACA was implemented, concurrently Medicare Part D was redesigned to gradually close the coverage gap ("donut hole"), reducing out-of-pocket costs for many beneficiaries but also introducing new cost-sharing structures that shifted financial responsibility over time—improving medication access for some patients while leaving others, particularly those with high-cost or specialty drugs, still facing affordability challenges and complex coverage transitions.

- **The association between higher out-of-pocket costs and medication abandonment is a pressing issue. Unfortunately, the 340B program has no legal requirements that covered entities invest any of their profits from the program into helping patients afford their medicines. The results of this analysis suggest that without any requirements for how 340B revenue is used, covered entities generally are not lowering patients' out-of-pocket expenses.**

Conclusion

Rather than continuing to empower large chains and pharmacy benefit managers through contract pharmacy mandates, policymakers must pivot toward comprehensive, systemic federal reforms that prioritize community health outcomes over corporate profits.

The billions of 340B dollars currently flowing through margin-motivated entities should be redirected and reinvested directly into the communities they were designed to serve. This reorientation back to its core mission would ensure that the 340B program more directly helps patients afford their medicine(s). This change would help address the underlying social determinants of health that disproportionately affect vulnerable populations, including rural and predominately Black communities alike.

Only through such deliberate policy shifts can we transform the current system from one that concentrates wealth and power in the hands of a few large entities into one that genuinely fulfills its mission of providing equitable, community-centered health care for all.