340B Considerations for Self-funded Employers

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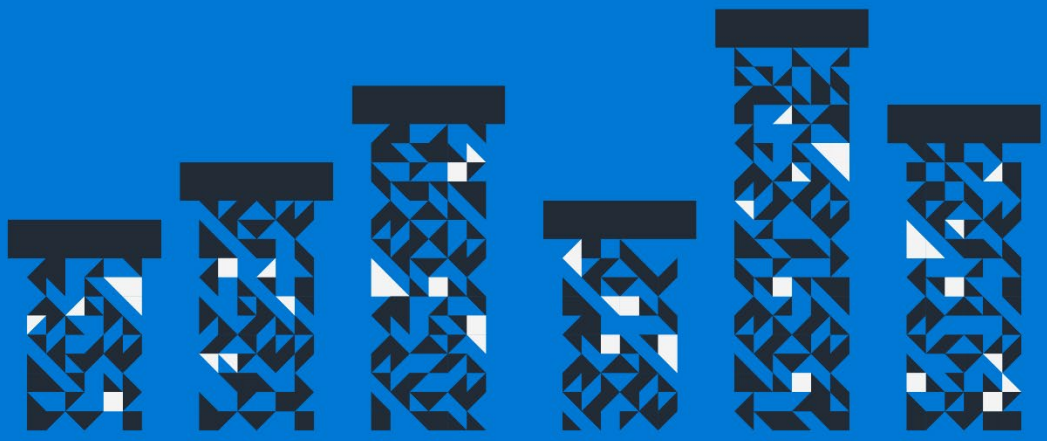

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Executive summary

Genentech engaged Milliman to highlight the impact of the 340B Drug Pricing Program on employers and summarize actions self-funded employers may consider to manage pharmaceutical drug costs associated with 340B. The 340B program is highly consequential for employers and plan sponsors, directly affecting rebate cash flows and net pharmacy spend. Managing 340B exposure through precise contract definitions, transparent data, and thoughtful network and formulary strategies can help preserve rebate integrity and reduce audit and claw back risk.

Since 2010, purchases of outpatient drugs under the 340B program have increased from $6.6 billion to roughly $81.4 billion in 2024, driven by an increase in the number of covered entities, as well as the proliferation of contract pharmacies – pharmacies that partner with covered entities to dispense 340B drugs to eligible patients.[1,2] For employers and plan sponsors, the scale is consequential: 340B claims are typically excluded from rebate guarantees and ineligible for rebate payments in pharmacy benefit manager (PBM) contracts, and according to a Milliman study commissioned by Pharmaceutical Research and Manufacturers of America, are associated with higher cost drug utilization, which could elevate net plan spend for 340B claims.[3] With the increase in covered entities and contract pharmacies, more claims have the potential to be ineligible for manufacturer rebates – a key issue for plans given that rebates average roughly 25% of gross pharmacy costs.

Employers often have limited ability to control utilization at 340B covered entities, however, they can influence how these claims are treated in their PBM contracts. For the most direct path to mitigate these risks, employers may wish to consider the following items in their PBM agreements and benefit designs:

PBM contracting and reporting

- Add a precise, narrow definition of 340B (e.g., by submission clarification codes, basis-of-cost fields, and provider types) to avoid over-excluding non-340B claims from rebate guarantees.
- Request quarterly, claim-level reporting plus audit rights on 340B volumes by pharmacy, identification methods, and financial impact to avoid missing out on rebates due to misclassified claims or inconsistencies in how 340B claims are processed.
- Require clear, time-limited claw back protocols for 340B claims (e.g., claw backs cannot occur > one year post rebate payout).
- Determine whether the PBM operates as a 340B contract pharmacy and explore the ability to work with non-contract pharmacies to fulfill specialty drugs.
- While excluding 340B claims from rebate guarantees is standard, ensure these claims are not excluded from network discount or dispensing-fee guarantees.

Pharmacy network

- Evaluate selective or exclusive specialty networks to limit which pharmacies are included in the network. Plan sponsors should consult with their legal counsel to ensure any network strategies are legally permitted for the states in which the plan operates.

Benefit design

- Evaluate low net cost formularies that emphasize lower-WAC options and generics, which are generally less exposed to 340B-related rebate impact and generally more affordable for patients on high-deductible health plans with co-insurance and deductibles.
- Understand how 340B incentives, including any "shared savings arrangements" with providers, may increase net costs directly and may drive utilization to higher-cost sites of care.

[1] https://www.drugchannels.net/2025/10/the-340b-contract-pharmacy-market-in.html

[2] https://www.hrsa.gov/opa/implementation-contract

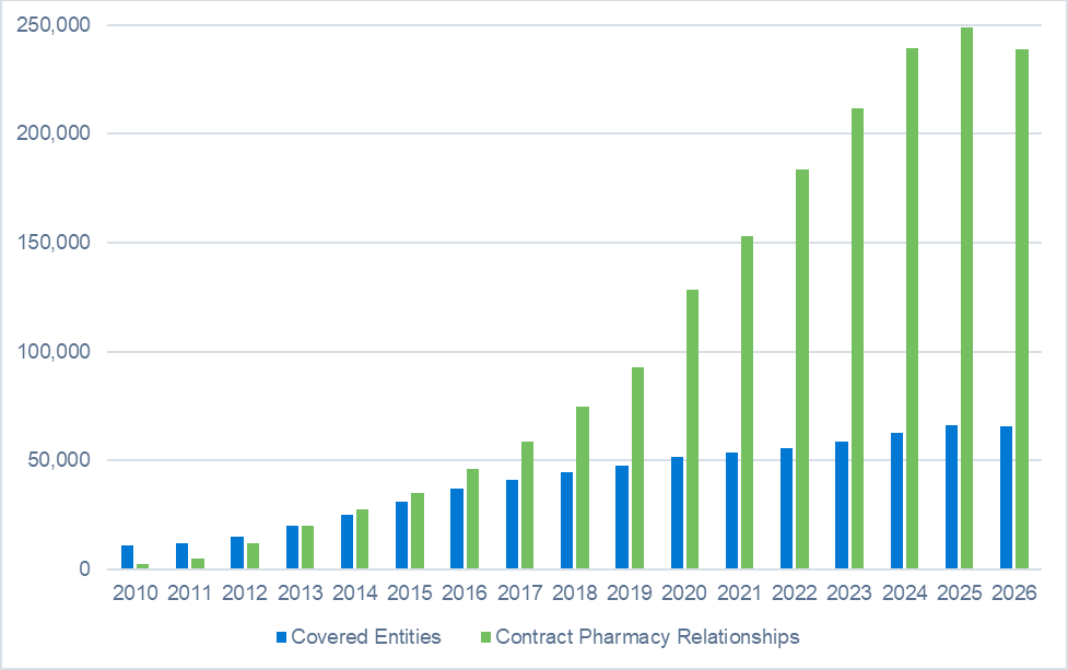
[3] https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/7-31-25_Analysis-340B-commercial-and-Medicare-outpatient-drug-spend.pdf

Growth of the 340B program

The federal 340B Drug Pricing Program requires drug manufacturers to provide covered entities outpatient drug products at significantly reduced prices.[4] On average, these covered entities realize savings between 20% to 55%[5,6] below list price of 340B drugs, with some medications available for as little as a penny.[7] Covered entities acquire drugs at deeply discounted rates and generate revenue by billing at prevailing commercial or government reimbursement levels. Importantly, while many 340B hospitals qualify for the program by serving a certain threshold of low-income and uninsured patients, they are permitted to dispense 340B-discounted drugs to all of their patients, regardless of insurance status.[8]

Since its inception, the 340B program has seen significant evolution and growth. In 2010, covered entities purchased $6.6 billion in drugs through the 340B program – a figure that surged to $81.4 billion in 2024.[9,10] Figure 1 below shows the growth of 340B covered entities and contract pharmacy relationships from 2010 to 2026.

FIGURE 1. NUMBER OF 340B COVERED ENTITIES AND CONTRACT PHARMACY RELATIONSHIPS FROM 2010 TO 2026



Based on Milliman analysis of data from HRSA as of February 2026

These developments have collectively transformed the scale and impact of the 340B program over the past fifteen years. The substantial growth of the 340B program is important for employers, as 340B claims typically are not eligible for manufacturer drug rebates, resulting in employers bearing the gross cost of these medications.

[4] https://www.hrsa.gov/opa

[5] https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2024/iqvia-update-on-size-of-340b-program-report-2024.pdf

[6] https://www.help.senate.gov/imo/media/doc/4510f17b-be5d-0f1a-2145-03e2950e1602/Rosenberg%20Testimony.pdf

[7] https://media.thinkbrg.com/wp-content/uploads/2024/05/13163125/340BProgram_Relative_Size_WP_2022Update.pdf

[8] https://schaeffer.usc.edu/research/misaligned-incentives-340b/

[9] https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf

[10] https://www.hrsa.gov/opa/updates/2024-340b-covered-entity-purchases

340B impact on drug costs

The 340B program allows eligible hospitals and providers to purchase outpatient drugs at significantly reduced prices; however, these discounted prices do not necessarily pass through directly to patients utilizing these drugs or payers.[11] Instead, covered entities generally bill and receive reimbursement at standard commercial reimbursement levels.[12] This markup creates a differential between the discounted drug acquisition cost and the reimbursement received, which in turn, creates a financial incentive to dispense higher-margin, brand-name, and specialty drugs – even if a less expensive, clinically appropriate generic or biosimilar is available.[13,14] For commercially insured patients, cost sharing is typically based on the undiscounted list price of the drug. As a result, the prescribing patterns at 340B hospitals, which may favor higher-cost drugs and lower utilization of less expensive biosimilars[15], can lead to increased cost sharing and potentially higher insurance premiums for plans and patients. One study estimated the growth in 340B was associated with an 8% increase in employer-based premiums from 2017 to 2023.[16]

Impacts are also felt by patients, as evidence suggests that the program may lead to higher out-of-pocket costs rather than direct savings for patients. While the 340B program reduces drug acquisition costs for hospitals, these savings are often not passed on directly to patients utilizing these prescriptions.[17]

Self-funded employer considerations

The proportion of 340B claims has a direct and significant impact on plan sponsor rebates. Claims identified as 340B are typically ineligible for rebate payments and excluded from rebate guarantees in PBM contracts. This means that as the share of 340B claims increases, the total volume of claims eligible for manufacturer rebates (and thus the rebate payments passed through to plan sponsors) decreases. A 2024 analysis estimated that the 340B program increases drug costs by 4.2% for self-insured employers due to the loss of manufacturer rebates.[18]

Figure 2 below represents an illustrative example for employers demonstrating stakeholder dynamics for a non-340B eligible claim compared to a 340B eligible claim. In this example, we model a drug with $10,000 gross cost, a 30% plan rebate ($3,000), no point-of-sale rebate, and a 50% 340B discount ($5,000).

FIGURE 2: ILLUSTRATIVE EXAMPLE DEMONSTRATING STAKEHOLDER DYNAMICS FOR A 340B ELIGIBLE CLAIM COMPARED TO A NON-340B ELIGIBLE CLAIM

	FORMULA	NON 340B ELIGIBLE	340B ELIGIBLE
Gross drug cost	A	$10,000	$10,000
Drug manufacturer rebate (30%)	B	$3,000	$0
Drug manufacturer 340B discount (50%)	C	$0	$5,000
Member paid (20% Coinsurance) *	D = A * 20%	$2,000	$2,000
Net plan paid amount	**E= A - B - D**	**$5,000**	**$8,000**

**Members may be able to use copay assistance programs to cover their out-of-pocket expenses.*

In this illustrative example, the net amount paid by the plan is higher for the 340B eligible claim, as the claim is ineligible for rebates.

[11] https://www.gao.gov/assets/gao-18-480.pdf

[12] https://www.appliedpolicy.com/the-340b-drug-pricing-program-origins-and-ongoing-questions/

[13] https://www.gao.gov/assets/d15442.pdf

[14] https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/7-31-25_Analysis-340B-commercial-and-Medicare-outpatient-drug-spend.pdf

[15] https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00812?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

[16] https://www.healthcapitalgroup.com/340b-state-insurance-premiums

[17] https://www.commonwealthfund.org/publications/explainer/2025/aug/340b-drug-pricing-program-how-it-works-and-why-its-controversial

[18] https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/iqvia-cost-of-340b-part-1-white-paper-2024.pdf

If 340B claims are not accurately identified and excluded from initial rebate payouts, manufacturers may later conduct audits or otherwise identify ineligible 340B claims that were paid a rebate. PBM contracts may include provisions allowing for the claw back of previously paid rebates if 340B claims are retrospectively identified, shifting the risk of manufacturer rebate disbursement to the plan sponsor and negatively affecting plan sponsor financial forecasts and budgets. Therefore, the more 340B claims present in a plan's drug spend, the lower the potential rebate revenue for the plan sponsor, which could lead to retrospective financial adjustments. Plan sponsors should understand how 340B claims are contractually managed within their PBM contract to mitigate the risk of lost rebate revenue which can subsequently help ensure members have access affordable healthcare through reduced plan premiums or cost-share.

PBM CONTRACTING AND REPORTING CONSIDERATIONS

Due to the fact that rebates are typically ineligible for manufacturer rebate payments, 340B claims are generally defined items with specified treatment in financial guarantees in PBM contracts. Paired with the potential for material financial impact on employers[19], plan sponsors may want to understand and address treatment of 340B claims in PBM contracts.

While a majority of 340B spend is for outpatient drugs billed through the medical benefit[20], not all employers may receive rebates from their medical carrier. Additionally, the magnitude of rebate value is much greater under the pharmacy benefit.[21,22] Consequently, the pharmacy benefit - and the PBM's role in claim oversight - represents the most effective lever for employers to identify 340B utilization, protect their rebate eligibility, and effectuate the plan's patient access goals.

Commercial payers or plan sponsors may wish to consider steps such as the following to insert robust language regarding 340B reporting and treatment of claims into their PBM contracts:

- Clearly define 340B claims: Consider adding to the PBM contract a precise, independently auditable, and narrow definition of what constitutes a 340B claim, ideally referencing specific submission clarification codes (e.g., submission clarification code 20), basis of cost determination fields (e.g., 08), and/or pharmacy provider types (e.g., type 39 as identified by NCPDP Data Q data base) to specify that only truly known, eligible claims are excluded from rebate guarantees. Precise definitions within PBM contracts can have significant financial implications. For instance, if 340B were to be defined as any claim processed at a contract pharmacy identified on the HRSA-published list, this approach could inadvertently exclude a number of non-340B claims dispensed at any of the approximately 60% of the pharmacies in the U.S. that serve as contract pharmacies.[23] Such a definition would broaden the scope of excluded claims, potentially reducing the overall rebate payments to the plan sponsor.
- Reporting: Plan sponsors may request that PBMs provide quarterly reporting on 340B claim volumes, validation methodologies, and financial impact. This allows plan sponsors to understand the impact of 340B on their plan and ensure proper identification of 340B claims
- Understand impacted guarantees: While PBMs may exclude 340B claims from rebate guarantees in the contract, plan sponsors should consider avoiding allowing PBMs to exclude these claims from network discount or dispensing fee guarantees. While 340B eligibility has a real impact on manufacturer rebate payments, it generally does not impact pharmacy network reimbursement in a similar manner.
- 100% pass-through of rebates: Consider adding provisions in contracts to require the PBM to pass-through 100% of manufacturer rebate value received, regardless of how a claim is classified or if it is excluded from any guarantees.
- Require transparency and data sharing: Consider including provisions in contracts to require PBMs to provide claim-level data for audit purposes, including rebate rejections, enabling plan sponsors to verify any claims identified as 340B and to reconcile rebates if 340B claims are retrospectively identified. Plans may

[19] https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/iqvia-cost-of-340b-part-1-white-paper-2024.pdf

[20] https://www.cbo.gov/publication/61730#_idTextAnchor035

[21] https://www.psgconsults.com/blog/untapped-potential-medical-drug-rebate-strategies-for-payers

[22] 2022 State of Specialty Spend and Trend Report available for download here: https://www.psgconsults.com/industry-report/specialtyreport2022/

[23] https://www.drugchannels.net/2025/10/the-340b-contract-pharmacy-market-in.html

request the right to an audit trail for any rebate payment rejection, including any manufacturer rejection response and supporting documentation.

- Claw-back provisions: 340B claw back language in PBM contracts is designed to protect plan sponsors from financial exposure when rebates have been paid on claims that are later identified as 340B eligible and therefore ineligible for manufacturer rebates. Consider adding provisions in contracts to provide detailed reporting on any claw backs and outline time-limited claw back protocols.
- Financial impact analysis: When evaluating any PBM offers, plans should consider conducting a financial impact analysis to quantify any differences in financial value attributable to variations in 340B, other definitions, and other terms and conditions.

By implementing well-considered strategies such as these, commercial payers and plan sponsors can seek to maintain greater rebate integrity and minimize financial exposure related to 340B claims in their PBM contracts, helping to ensure members have access to affordable healthcare.

PHARMACY NETWORK CONSIDERATIONS

There are several state laws prohibiting PBMs from discriminating against covered entities and/or contract pharmacies based on their participation in the 340B program.[24] While complying with these laws, plans may consider other compliant actions to mitigate the financial risks associated with 340B. Some potential examples plans may want to consider include:

- A narrow or exclusive specialty network can help protect a plan from 340B impacts by limiting which pharmacies are included in the network, thereby controlling whether covered entities and their contract pharmacies can participate in dispensing drugs to plan members. Narrow and exclusive specialty networks give the plan sponsor more control over where prescriptions are filled. Note, many of the largest specialty pharmacies are contract pharmacies.
- Plan sponsors may consider asking their PBM not to operate as a contract pharmacy. PBMs often own or affiliate with specialty and mail-order pharmacies, and these PBM-owned pharmacies may participate as contract pharmacies in the 340B program, sometimes generating significant revenue (25% to 35% of 340B discount) from 340B claims.[25] In 2025, CVS Health maintained 77,000 contract pharmacy relationships with covered entities, while Express Scripts and Optum Rx had 15,000 and 13,000 such relationships, respectively.[26] During the PBM request for proposal (RFP) or contracting process, plan sponsors may consider requesting that the PBM not act as a contract pharmacy and responding PBMs may determine if they are able to fulfill this request. Note, pharmacies who act as 340B contract pharmacies do so across their entire book and it may not be feasible for the pharmacy to change its 340B contract pharmacy status for one client. If a PBM is unwilling or unable to cease contract pharmacy operations, plan sponsors may wish to explore specialty pharmacy network relationships with pharmacies that are willing to meet this request.

FORMULARY CONSIDERATIONS

Low net cost formularies focus on selecting drugs with the lowest overall cost to the plan, often favoring lower wholesale acquisition cost (WAC) options and generics, rather than prioritizing drugs that offer the highest manufacturer rebates. This approach has the potential to significantly decrease the impact of the 340B program on plan sponsors from lost or clawed back rebates.

When a plan sponsor uses a high-WAC, high-rebate formulary, they are covering higher cost brand drugs that generate relatively larger rebates. As 340B claims are often excluded from PBM rebate guarantees, when a plan sponsor uses a high-WAC, high rebate formulary they create risk that they do not receive a rebate for 340B eligible high-WAC drugs. The more reliant a formulary is on rebates for financial performance, the greater the risk that rebate in-eligibility materially adversely impacts plan financials.

By contrast, a low net cost formulary incentivizes utilization of lower-WAC drugs (e.g., generics, biosimilars) that are less dependent on rebates to achieve a low net cost or reduce plan liability. This generally leaves plan sponsors less reliant on rebates, and less exposed to the financial risk of rebate ineligibility. Plan sponsors may wish to seek to

[24] https://www.nachc.org/issues-advocacy/state-level-340b-laws-and-legislation-tracker/

[25] https://www.drugchannels.net/2023/07/exclusive-for-2023-five-for-profit.html

[26] https://www.drugchannels.net/2025/10/the-340b-contract-pharmacy-market-in.html

understand the value of 340B exclusions by asking for reporting from their PBM, particularly for drugs with lower WAC options available.

MEDICAL BENEFIT CONSIDERATIONS

Provider administered drugs, generally reimbursed under the medical benefit, have distinctly different management techniques and considerations for employers. For example, provider administered drugs are generally managed by medical policies instead of a formulary, as utilized under the pharmacy benefit. Many competitive classes of provider administered drugs, including biosimilar classes, receive rebates from drug manufacturers. However, rebates on provider administered drugs are generally much lower in absolute magnitude than the rebates received for drugs reimbursed under the pharmacy benefit. While rebates on specialty drugs under the pharmacy benefit are approximately 35%, on average, rebates on specialty drugs under the medical benefit represent only 3% of gross drug cost.[27] This is reflective of the lower absolute magnitude of spend on medical drugs as well as the mix of products with high cost conditions like oncology, immunology, and multiple sclerosis driving medical benefit expenditure. Also, generally speaking, state laws regulating PBMs and the general push towards rebate transparency and pass-through of rebates has not necessarily made the same progress in recent years with the medical benefit. The strategies for managing 340B with a PBM can also apply to managing 340B with an employer's health plan or third-party administrator. Additional considerations for employers: understand medical policy and preferred drug strategy (e.g., management to lowest net cost for clinically effective products), understand the role of medical rebates and if rebates are passed through to the employer, consider site of care strategies and incentivizing utilization at lower cost site of care (e.g., ambulatory infusion clinics, home infusion, provider office).

CONSIDERATIONS AROUND 340B SHARED SAVINGS PROGRAMS

Some employers are exploring strategies to mitigate the impact of 340B on their costs, such as considering direct contracting with hospitals or third-party vendors to share in 340B savings. In certain cases, providers or vendors may offer to share a portion of the 340B revenue with employers to attract a higher volume of commercially insured patients to their facilities. The programs, sometimes called 340B shared savings programs, can influence claim volumes and reimbursement rates, further impacting the financial outcomes for both providers and plan sponsors. These programs generally entail driving all or a portion of medical and pharmacy utilization to a covered entity, and may include strategies like telehealth programs, which leverage remote care to expand access and utilization of discounted medications. These programs are advantageous for covered entities, as commercial insurance typically has higher reimbursement and thus the covered entity appreciates more favorable reimbursement.

However, some have expressed concern that these 340B shared savings programs may ultimately lead to increased healthcare costs for employers and employees due to the covered entities' incentive to prescribe higher cost drugs, increased hospital consolidation, and potential shifts to higher-cost sites of care.[28] The plan sponsor may also incur administrative or operational costs to implement these programs. One analysis that took into account lost rebates, shift to higher cost sites of care (e.g., hospitals), shifts to higher cost drugs, and expanded 340B eligibility estimated that 340B shared savings programs would increase employer healthcare costs by 14%, on average.[29] Plan sponsors may want to evaluate these items when considering participation in a 340B shared savings program. Plan sponsors may want to understand the current net cost for those drugs, not just rebate guarantees, to determine how a shared savings program may impact plan costs and contracting with their PBM. As many plans may not have insight into their current drug-level net costs, it may be difficult for plans to make an informed decision on these programs and evaluate the financial impact and impact to employees of these programs.

OUTLOOK OF THE 340B PROGRAM

The 340B program is undergoing transformation, driven by marketplace innovations and regulatory developments. Several models have been proposed to pilot changing how 340B covered entities receive 340B discounts.[30,31] Under one proposed model, covered entities would pay the full price for eligible drugs upfront and then receive a rebate

[27] 2022 State of Specialty Spend and Trend Report available for download here: https://www.psgconsults.com/industry-report/specialtyreport2022/

[28] https://www.nationalalliancehealth.org/wp-content/uploads/NA-Action-Brief-Employer-Shared-Savings-Final.pdf

[29] https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2024/the-cost-of-the-340b-program-part-2-340b-revenue-sharing.pdf

[30] https://www.hrsa.gov/opa/340b-model-pilot-program

[31] https://www.fiercehealthcare.com/providers/trump-administration-restarts-its-efforts-pilot-340b-rebates

reflecting the difference between the WAC and the 340B ceiling price. These types of models are generally designed to address concerns about ambiguity, oversight, and duplicate discounts in the traditional 340B upfront discount model and are applicable to all covered entity types.[32] There is also a considerable amount of litigation over implementation of the 340B statute that adds uncertainty to the future outlook of the program.[33]

Finally, there is growing momentum for establishing a national, independent clearinghouse to collect and verify 340B data.[34,35] Such a clearinghouse would be designed to enhance compliance and help prevent duplicate discounts, addressing a longstanding operational challenge for manufacturers, covered entities, and payers. Note that despite these potential changes to the 340B program, neither the proposed programmatic nor legislative modifications would address the full impact of the 340B program on plan sponsors and beneficiaries.

[32] https://www.federalregister.gov/documents/2026/02/17/2026-03042/request-for-information-340b-rebate-model-pilot-program

[33] https://www.congress.gov/crs-product/R48696

[34] https://rwc340b.org/hrsa-340b-rebate-model-pilot-program-more-limited-than-anticipated-but-still-concerning-to-covered-entities-on-several-fronts/

[35] https://www.pshcks.org/rxparadigm-partners-with-prairiestar-health-center-to-launch-tungsten-plus-a-neutral-340b-clearinghouse-solution/

Caveats and Limitations

This report is intended to provide considerations for commercial plan sponsors on the impact of the 340B drug pricing program to their employee plan benefits. This information may not be appropriate and should not be used for other purposes.

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Any releases of this report to a third party should be in its entirety. If this report is referenced, it should be made available in its entirety to avoid information potentially being misinterpreted due to being out of context.

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