What States can Learn From 340B Transparency

Evidence from Minnesota

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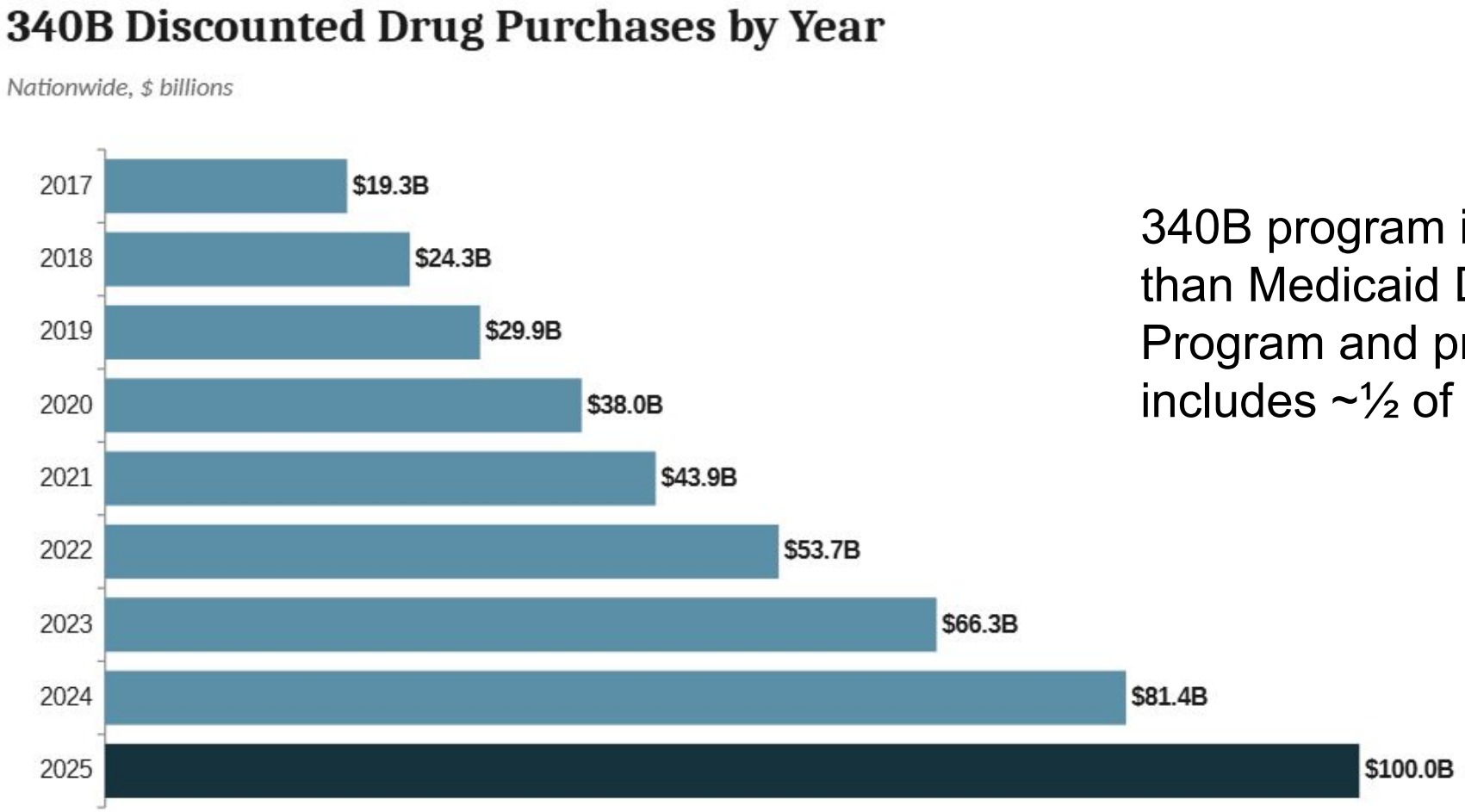
NCOIL 2026 Summer National Meeting
Boston, MA
July 16, 2026

Disclaimer: My views do not represent the University of Minnesota, nor do

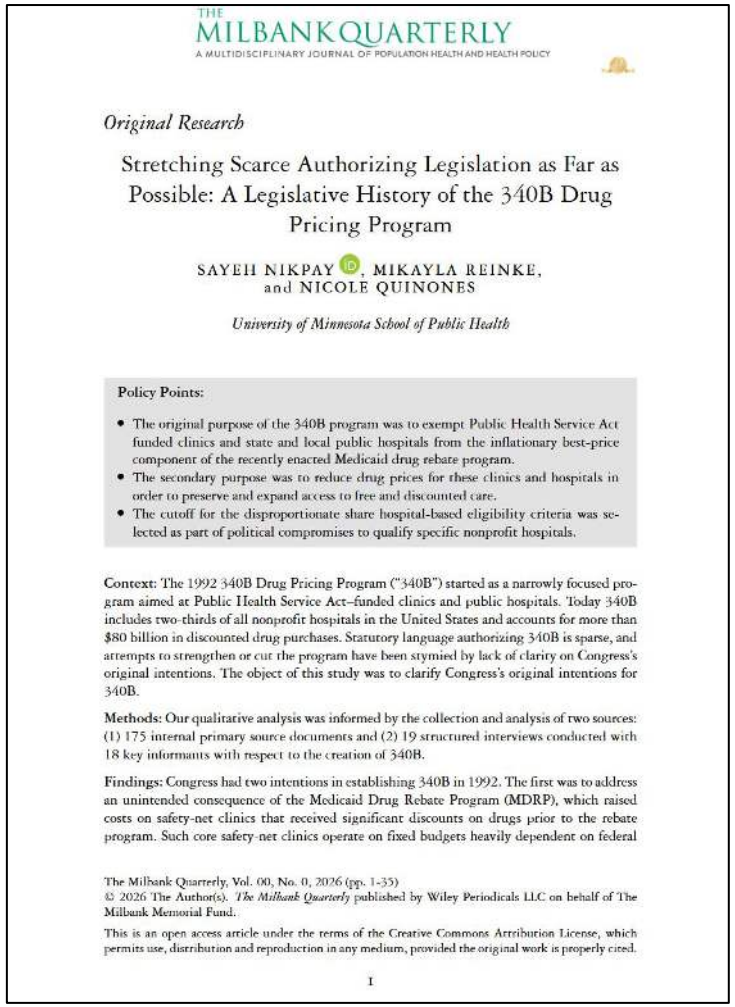
340B is Large and Growing



340B program is now larger than Medicaid Drug Rebate Program and program includes ~½ of US hospitals

Source: HRSA 340B Covered Entity Purchases, 2017–2025 (via Apexus Prime Vendor Program data); Drug Channels Institute analysis. 2025 figure released July 13, 2026.

340B was Originally Intended to be a Small Program



THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Original Research

Stretching Scarce Authorizing Legislation as Far as Possible: A Legislative History of the 340B Drug Pricing Program

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Policy Points:

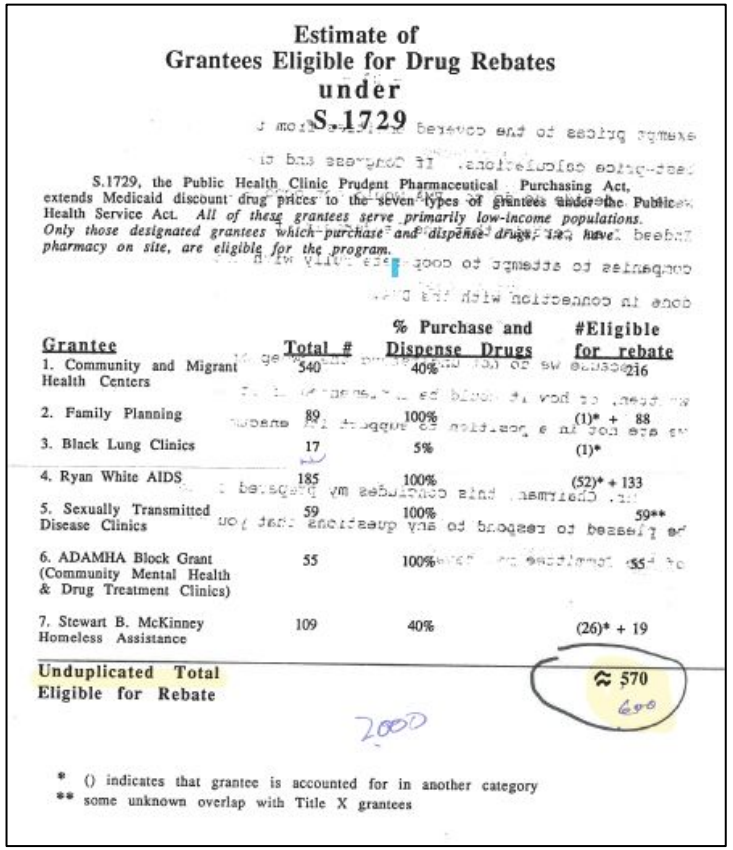
- The original purpose of the 340B program was to exempt Public Health Service Act funded clinics and state and local public hospitals from the inflationary best-price component of the recently enacted Medicaid drug rebate program.
- The secondary purpose was to reduce drug prices for these clinics and hospitals in order to preserve and expand access to free and discounted care.
- The cutoff for the disproportionate share hospital-based eligibility criteria was selected as part of political compromises to qualify specific nonprofit hospitals.

Context: The 1992 340B Drug Pricing Program ("340B") started as a narrowly focused program aimed at Public Health Service Act–funded clinics and public hospitals. Today 340B includes two-thirds of all nonprofit hospitals in the United States and accounts for more than $80 billion in discounted drug purchases. Statutory language authorizing 340B is sparse, and attempts to strengthen or cut the program have been stymied by lack of clarity on Congress's original intentions. The object of this study was to clarify Congress's original intentions for 340B.

Methods: Our qualitative analysis was informed by the collection and analysis of two sources: (1) 175 internal primary source documents and (2) 19 structured interviews conducted with 18 key informants with respect to the creation of 340B.

Findings: Congress had two intentions in establishing 340B in 1992. The first was to address an unintended consequence of the Medicaid Drug Rebate Program (MDRP), which raised costs on safety-net clinics that received significant discounts on drugs prior to the rebate program. Such core safety-net clinics operate on fixed budgets heavily dependent on federal

The Milbank Quarterly, Vol. 00, No. 0, 2026 (pp. 1-35)



Estimate of Grantees Eligible for Drug Rebates under S.1729

S.1729, the Public Health Clinic Prudent Pharmaceutical Purchasing Act, extends Medicaid discount drug prices to the seven types of grantees under the Public Health Service Act. *All of these grantees serve primarily low-income populations. Only those designated grantees which purchase and dispense drugs, i.e. have pharmacy on site, are eligible for the program.*

Grantee	Total #	% Purchase and Dispense Drugs	#Eligible for rebate
1. Community and Migrant Health Centers	540	40%	216
2. Family Planning	89	100%	(1)* + 88
3. Black Lung Clinics	17	5%	(1)*
4. Ryan White AIDS	185	100%	(52)* + 133
5. Sexually Transmitted Disease Clinics	59	100%	59**
6. ADAMHA Block Grant (Community Mental Health & Drug Treatment Clinics)	55	100%	55
7. Stewart B. McKinney Homeless Assistance	109	40%	(26)* + 19
Unduplicated Total Eligible for Rebate			≈ 570

* () indicates that grantee is accounted for in another category
** some unknown overlap with Title X grantees

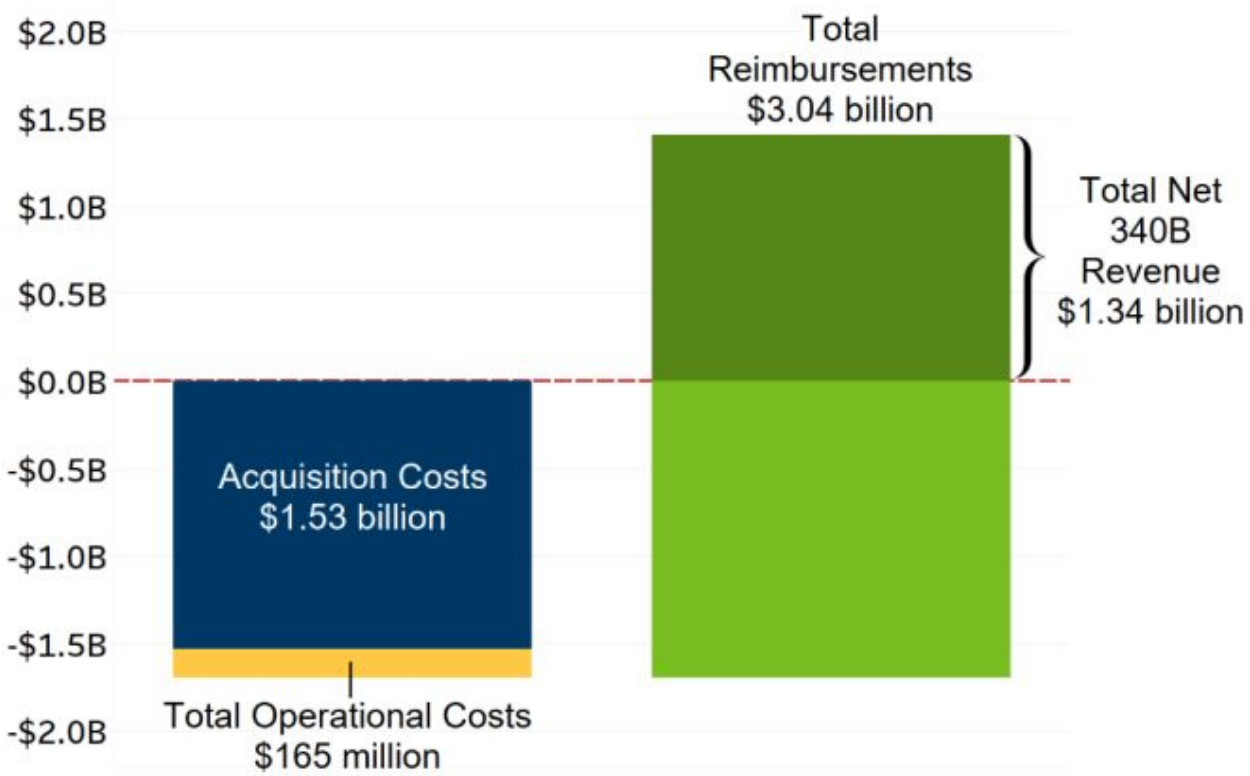
"Stretching scarce Federal resources" referred to lowering losses from operating free and sliding fee-scale care for Federal Grantees and ~200 public hospitals

As 340B has grown in size it has also grown in scope, interacting with health care system actors

Source:Nikpay, Reinke and Quninones (2026) https://www.milbank.org/quarterly/articles/stretching-scarce-authorizing-legislation-as-far-as-possible-a-legislative-history-of-the-340b-drug-pricing-program/

MN Transparency Passed to Learn 340B's Size and Scope

Figure 1: Summary of net 340B revenue and its components in Minnesota, 2024

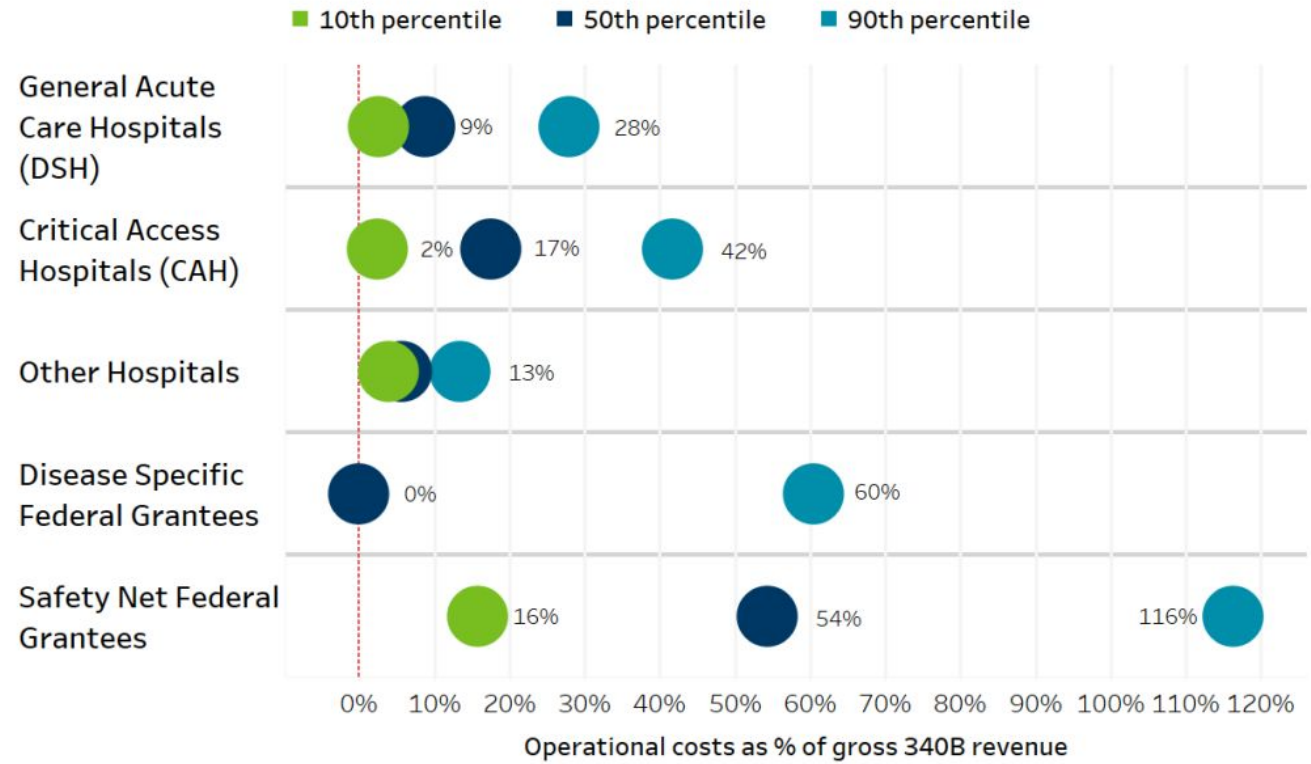


Source: MDH, Health Economics Program analysis of 2024 data reported by Covered Entities under the Minnesota 340B Covered Entity Report.

Source: https://www.health.state.mn.us/data/340b/docs/2025report.pdf

1 in $10 of 340B Revenue Accrues to Outside Parties

Figure 6: Distribution of total 340B operational costs as share of gross 340B revenue, 2024



Source: MDH, Health Economics Program analysis of 2024 data reported by Covered Entities under the Minnesota 340B Covered Entity Report.

Source: https://www.health.state.mn.us/data/340b/docs/2025report.pdf

Net 340B Revenue Highly Concentrated among Hospitals

Table 3: Data summary by Covered Entity groupings, 2024

Covered Entity Grouping	Count	Acquisition Costs ($)	Total Operational Costs ($)	Reimbursements ($)	Estimated Missing Reimbursements ($)	Net 340B Revenue ($)	Average Net 340B Revenue per Covered Entity ($)
General Acute Care Hospital (DSH)	23	1,146,283,931	126,256,917	2,321,198,531	33,722,213	1,082,379,896	47,059,995
Critical Access Hospital (CAH)	70	128,857,966	22,053,951	272,474,863	13,874,864	135,437,811	1,934,826
Other Hospital	9	151,053,325	7,562,181	234,487,194	16,430,106	92,301,794	10,255,755
Disease-Specific Federal Grantee	63	94,968,939	4,947,795	121,924,660	0	22,007,925	349,332
Safety Net Federal Grantee	16	9,392,014	3,931,942	21,467,494	0	8,143,538	508,971
Total	**181**	**1,530,556,175**	**164,752,786**	**2,971,552,742**	**64,027,183**	**1,340,270,964**	**7,404,812**

Source: MDH, Health Economics Program analysis of 2024 data reported by Covered Entities under the Minnesota 340B Covered Entity Report.

Source: https://www.health.state.mn.us/data/340b/docs/2025report.pdf

Commercial Patients the Primary Source of 340B Net Revenue

Table 5: Estimated net 340B revenue by Covered Entity groupings and select payer types, 2024

Covered Entity Grouping	Commercial ($, millions)	Medicare ($, millions)	Minnesota Health Care Programs (MHCP) ($, millions)	Estimated Total ($, millions)	% of Grand Total
General Acute Care Hospitals (DSH)	470	381	213	1,064	78.9%
Critical Access Hospitals	72	57	13	142	10.5%
Other Hospitals	57	36	17	110	8.2%
Disease-Specific Federal Grantees	6	2	14	22	1.6%
Safety Net Federal Grantees	3	3	4	10	0.7%
Estimated Total	608	479	261	1,348	100.0%
% of Grand Total	45.1%	35.5%	19.4%	100.0%	

Source: MDH, Health Economics Program analysis of 2023 and 2024 data reported by Covered Entities under the Minnesota 340B Covered Entity Report.

Source: https://www.health.state.mn.us/data/340b/docs/2025report.pdf

340B Also Jeopardizes Medicaid Drug Rebates

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Limitations of 340B Reporting

Difficult to standardize units across drug types (retail vs. administered)

Missing payment data for certain low-cost drugs “bundled” with other services

No information on contracts with outside parties

Drug-specific data is incomplete (only top 50 drugs)

Different reporting capabilities across covered entities

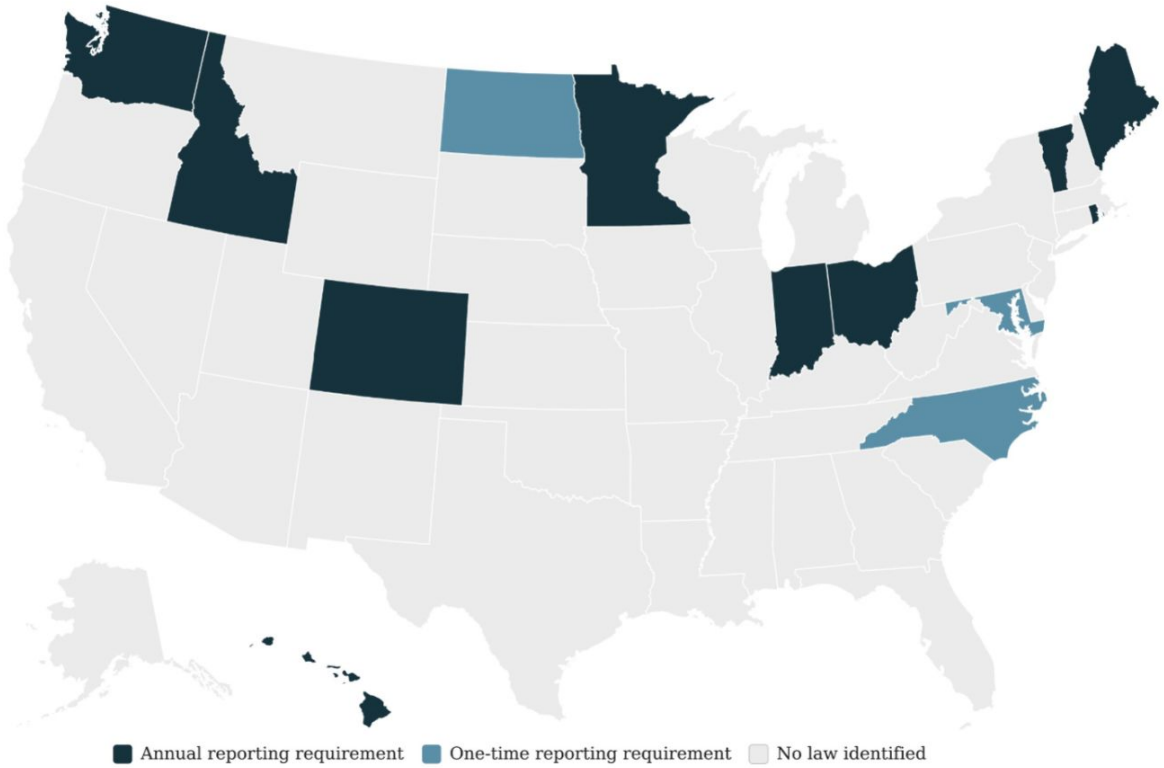
Difficult to compare data to external sources

Source: https://www.health.state.mn.us/data/340b/docs/2025report.pdf

Other 340B Transparency Efforts

State 340B Reporting Requirements, 2026

States with a 340B covered-entity financial reporting law, by reporting frequency



States plotted from the table as provided; all other states have no 340B financial reporting law identified in this dataset. Map: Albers USA projection.

Source: Reinke and Nikpay (2026) Available on Request

Proposed Federal, 2026

Tax-Exempt Hospital Transparency Act, SECURE 340B Act, 340B Access Act

Cassidy 340B Discussion Draft*

CMS Medicare Part D Reporting

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