

How Will the Medicare Drug Price Negotiation Program Affect 340B Covered Entity Finances?

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October 2026



Executive Summary

Background: The Medicare Drug Price Negotiation Program (MDPNP) gives the federal government, for the first time, the opportunity to negotiate "Maximum Fair Prices" (MFPs) for prescription drugs with manufacturers. The first ten drugs entered the program in 2026, and subsequent cohorts of 15-20 drugs are scheduled to be added each year. Covered entities enrolled in the 340B drug discount program are now eligible to purchase drugs from manufacturers at the lesser of the MFP and 340B price. However, they face revenue losses from statutory changes to Medicare reimbursement rates as well as spillover effects on prices negotiated with other payers.

Methods: This study uses calibration methods to predict the impacts of the MDPNP on covered entities' net revenues from the 340B program in both the short and long run. I account for the reduction in costs from MFP pricing, the direct reduction in revenue from the new Medicare payment rules, and the indirect reduction in revenue from renegotiated prices with other payers. I identify preferred parameter values and also conduct sensitivity analyses.

Results: Using the preferred calibration of parameters, I predict that the MDPNP will reduce covered entities' net revenue from the 340B program by $5.73 billion in 2027, rising to over $24 billion per year by 2036 as more drugs enter the program. The projected long-term reduction represents about one-third of all 340B net revenues.

Conclusions: Lowering prescription drug prices is an important policy objective. However, the manner in which the MDPNP does so presents a threat to the 340B program that will become increasingly severe over time.

I. Introduction

The Medicare Drug Price Negotiation Program (MDPNP), created by the Inflation Reduction Act of 2022 (IRA), authorizes the federal government to negotiate the prices of selected prescription drugs with manufacturers. The negotiated price is called the Maximum Fair Price (MFP). Drugs are eligible for inclusion if they have at least $200 million in Medicare expenditures, have been on the market for seven years (or eleven for biologic drugs), and do not face generic (or biosimilar) competition (Martin, 2025). MFPs were negotiated in 2024 for the first cohort of ten drugs, with their MFPs taking effect in 2026 (Centers for Medicare & Medicaid Services [CMS], 2024). The 2027 cohort of fifteen additional drugs was announced in 2025, the 2028 cohort will add fifteen more, and subsequent cohorts will consist of twenty drugs each (AHA News, 2025). While only Medicare Part D drugs are included in 2026 and 2027, physician-administered Part B drugs will be eligible starting with the 2028 cohort (Gurley et al., 2026).

This study examines how the MDPNP interacts with another major drug pricing program – 340B – in ways that, to my knowledge, have not been explored in the scholarly literature nor fully understood by covered entities themselves. The 340B program, which was created by the Veterans Health Care Act (VHCA) of 1992 (Public Law 102-585), had its roots in earlier legislation. The Medicaid Drug Rebate Program (MDRP), implemented in 1990 as part of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), required drug manufacturers to pay quarterly rebates to state Medicaid agencies based on a drug's "best price" across the market. This created an incentive for manufacturers to eliminate the informal, below-market pricing they had previously given to safety-net providers such as public hospitals, as those discounts lowered this "best price" (Martin, 2025).

The VHCA added a new Section 340B to the Public Health Service Act (PHSA) which required manufacturers to sell drugs to a defined list of covered entities at or below a statutorily

defined ceiling price. The ceiling price was derived from the MDRP's rebate amount, effectively giving covered entities Medicaid pricing on outpatient drugs. These covered entities were initially primarily Disproportionate-Share Hospitals (DSHs) with a Medicare DSH payment-adjustment percentage above a certain threshold, Federally Qualified Health Centers, and Ryan White HIV/AIDS clinics. The Deficit Reduction Act of 2005 added children's hospitals, and the Affordable Care Act (ACA) of 2010 added free-standing cancer hospitals, critical access hospitals (CAHs), rural referral centers, and sole community hospitals (Courtemanche and Garuccio, 2026).

340B pricing applies to drugs prescribed in an outpatient setting by covered entities and filled either at in-house pharmacies or external pharmacies with a contractual arrangement with covered entities, known as "contract pharmacies". When a 340B-eligible prescription is filled, the pharmacy collects payment in the same way it would for a non-340B fill. It then passes this payment on to the covered entity in return for a processing fee and a replacement drug that the entity purchases using its 340B discount (U.S. Government Accountability Office, 2018). The covered entity's margin is the difference between the amount patients and their insurers pay for the drug and the cost of its replacement. In this way, the program was designed to help safety-net providers "stretch scarce federal resources" as far as possible (Courtemanche and Garuccio, 2026). 340B has grown into a major funding source, with the amount of drug purchases made using the 340B discount reaching $100 billion in 2025 (Fein, 2026).

The combination of the MDRP and 340B raises the question of what happens for drugs prescribed by covered entities to Medicaid patients, as these would be eligible for both Medicaid rebates and 340B discounts. To address this issue, the 340B statute makes clear that a manufacturer cannot be required to provide both the discounted 340B price *and* a Medicaid drug rebate for the same unit of the same drug – a practice known as duplicate discounting (Public Law 102-585, 42 U.S.C. § 256b(a)(5)(A)).

A similar situation arises with the interaction of the MDPNP with 340B. Because a large share of Medicare-covered drugs are also purchased at a discount by 340B covered entities, the statute requires that a covered entity receive whichever price is lower between the 340B ceiling price and the MFP (Santiago and Moldawer, 2025). At first glance, this makes the MDPNP sound favorable to covered entities, as they are now able to purchase drugs at a deeper discount when their MFPs are lower than their 340B prices. However, MFPs are accompanied by substantial reductions in Medicare drug reimbursement rates, which can be expected to lead to spillover effects on commercial payers due to the way in which drug prices are negotiated. This means a reduction in covered entity revenues that is likely larger than the reduction in costs because it accrues across a much broader base of purchases.

This paper aims to quantify the short- and long-run effects of the MDPNP on covered entities' net revenues from the 340B program, taking into account the mechanical effects of the new price ceiling on both costs and Medicare revenues as well as the spillover effects from changes in the market prices of affected drugs. My analysis shows that the revenue reduction will far outweigh the cost reduction, leading to a net negative effect on covered entities. Under preferred parameter calibration, I estimate a net revenue loss of $5.73 billion in 2027 that increases to over $24 billion annually within ten years. *The long-run projection represents a 33% reduction in total covered entity net revenue from the 340B program* – an enormous shock that could trigger service reductions at or closures of hospitals and other safety-net providers.

II. Direct Mechanical Effect on Covered Entity Costs

I begin the analysis with the cost side, where the change – in isolation – favors covered entities. When a prescription is eligible for both a 340B discount and an MFP, the law states that the manufacturer must provide the covered entity the lower of the 340B ceiling price or the MFP (Gurley et al., 2026; Santiago and Moldawer, 2025). If the 340B price is lower than the new MFP,

the covered entity purchases the drug at the same price as before. If the MFP is lower than the 340B price, the covered entity now purchases at the new, lower price. Even though the discounts cannot be stacked on top of each other, covered entities cannot experience a higher cost than before MFPs. Drug-level data show that the 340B price is below the MFP price for about 85% of the 2026 cohort of drugs' national drug codes, but only about 41% for the 2027 cohort (Young, 2025). Therefore, the direct mechanical effect on covered entity costs has been minimal thus far but will grow next year.

To estimate the size of the mechanical cost effect, the first step is to establish a baseline. In 2025, covered entities purchased $100 billion of drugs at 340B prices (HRSA, 2026a). Based on wholesale acquisition cost (WAC) – the list price manufacturers charge wholesalers before any rebates or discounts – the value of these drugs was $179.5 billion (IQVIA Institute for Human Data Science, 2026). WAC appears to be a reasonable approximation of the price paid to pharmacies for commercially insured patients, implying a margin of 79.5%. Commercial pharmacy contracts are typically benchmarked to average wholesale price (AWP) minus 16-18% (Fein, 2015), and AWP is roughly WAC × 1.20 (Aird and Counterman, 2026), implying a price paid equal to 99.6% of WAC. Medicare Part D prices paid tend to be similar since those are also negotiated by commercial pharmacy benefit managers (PBMs), and Medicaid managed care organizations (MCOs) have also typically reimbursed at around WAC (Dolan and Tian, 2020; Medicaid and CHIP Payment and Access Commission [MACPAC], 2026).

The main exception is traditional fee-for-service (FFS) Medicaid, for which a federal regulation limits reimbursement for 340B-eligible drugs to actual acquisition cost (the 340B ceiling price) plus a small dispensing fee that is typically around $10 (42 CFR § 447.518(a)(2); MACPAC, 2018; Gifford et al., 2020; Wachino, 2016). Since the MDPNP's cost-plus-6% reimbursement structure – discussed in more detail in the next section – was modeled after Medicaid's, it seems reasonable to assume that $10 roughly equates to 6%. Traditional Medicaid fee-for-service (FFS)

covers 22% of Medicaid enrollees nationwide as well as 22% of expenses (Hinton et al., 2026; Kaiser Family Foundation, 2026). Additionally, eight states carve out prescription drug benefits for Medicaid managed care enrollees and administer them through FFS with the same cost + dispensing fee reimbursement structure (Gifford et al., 2024). These states (CA, MO, ND, NY, OH, TN, WI, and WV) combined have 38.4% of the U.S.' Medicaid managed care population of 66,512,237 (Kaiser Family Foundation, 2026). With managed care covering 78% of those on Medicaid, this translates to 30% of all Medicaid enrollees – a percentage that I assume also applies to drug spending. In short, an estimated 52% of Medicaid drug spending is through FFS and 48% through managed care.

Taking the weighted average of the 340B margins for these different payers gives an estimate of the overall baseline (pre-MDPNP) margin covered entities make from the program. To my knowledge, the only data on the breakdown of 340B-eligible purchases by payer comes from Minnesota, where 20% of fills are paid by Medicaid (Minnesota Department of Health, 2024). Assuming this percentage applies to the whole country implies that the share of 340B fills paid by Medicaid FFS is 20% * 52%, which yields 10.4%. Therefore, the weighted average margin is 6% * 10.4% + 79.5% * 89.6% = 71.9%. This in turn implies $171.9 billion in covered entity revenue from their $100 billion of 340B-discounted purchases, for a baseline net revenue of $71.9 billion.

The next step is to compute the difference between MFP and 340B pricing for the drugs for which MFP is lower. Unfortunately, since 340B prices are not public, it is not possible to calculate these differences precisely. As an approximation, we can assume the 15% of drug codes in the 2026 MFP cohort with lower prices than 340B are the ones that have the largest discount relative to WAC. However, drug-code level WACs are also not publicly available, so the analysis needs to use broader drug-level WACs. To do this, I assume that the discount relative to WAC is the same for each drug code (dose, etc.) of a given drug. Since the 2026 cohort contains only ten drugs, 15% comes to 1.5,

which rounds to two. I therefore take the two drugs with the biggest discount relative to WAC and assume that those are the two for which the MFP price is below the 340B price. Those are Januvia with a 79% discount and NovoLog/Fiasp with a 76% discount, for an average of 77.5% (Office of the Assistant Secretary for Planning and Evaluation (ASPE), 2024). In contrast, the average 340B discount relative to WAC is $79.5 billion on a base of $179.5 billion, or 44.3%. Since the specific 340B discount for Januvia and NovoLog/Fiasp is not public information, I assume it is equal to this average. Therefore, for the two drugs in question, these calculations imply that the additional discount from MFP pricing over and above 340B pricing is 33.2 percentage points relative to WAC.

Next, we need to know annual Part D spending on these two drugs, as well as how much of it was 340B-eligible. In 2022 – the most recent year in which the data are available – Part D spending was $4.1 billion on Januvia (ASPE, 2023a) and $2.54 billion on NovoLog/Fiasp (ASPE, 2023b). According to Dickson et al. (2023), 9.6% of Part D claims are 340B-eligible. Assuming this percentage applies to these two drugs yields 340B-specific amounts of $394 million for Januvia and $244 million for NovoLog/Fiasp, for a total of $638 million. Further assume that these purchases were made at WAC, since that is roughly the rate at which Part D reimburses pharmacies (Aird and Counterman, 2026; Fein, 2015; U.S. Department of Health and Human Services, Office of Inspector General, 2005), and that the MFP program will not change the number of units purchased of these drugs. Then, the decrease in covered entity costs from being able to purchase replacement drugs at the MFP prices rather than 340B prices is 33.2% of $638 million, or $212 million.

A similar analysis can be conducted for the 2027 cohort of MFP drugs. 59% of these drugs will have MFP prices that are lower than 340B prices (Young, 2025). Under the same assumptions as above, this implies that the nine of the fifteen drugs with the lowest MFP prices relative to WAC are the ones with a bigger discount than 340B. These are, with their percentage discount in parentheses: Janumet/Janumet XR (85%), Tradjenta (84%), Breo Ellipta (83%), Linzess (75%),

Trelegy Ellipta (73%), Ozempic/Rybelsus/Wegovy (71%), Otezla/Otezla XR (65%), Xifaxan (63%), and Pomalyst (60%) (CMS, 2025c). The average percentage discount is therefore 73.2%, or 28.9 percentage points greater than the average 340B discount. Total Part D spending on these drugs combined is $29.36 billion (CMS, 2025c). Assuming 9.6% of these expenditures are 340B-eligible yields $2.82 billion. This makes the increase in covered entity net revenue from switching from 340B prices to MFP prices for these drugs equal to 28.9% of $2.82 billion, or $815 million. Therefore, once both cohorts of drugs are active in the MFP program, *I estimate a $1.027 billion increase in covered entity net revenue from the direct mechanical effect. While non-trivial, this is a relatively small 1.4% of the $71.9 billion of overall 340B net revenue estimated earlier.*

III. Direct Mechanical Effect on Covered Entity Revenues

The MFP also mechanically reduces the revenue for covered entities. According to MDPNP rules, Part D will reimburse pharmacies only the MFP plus a nominal dispensing fee – a similar payment system to the one used by Medicaid (CMS, 2025b; Coster, 2025). For Part B, reimbursement is limited to MFP plus 6% (Stryker Blasch et al., 2026).[1] For simplicity, assume that the dispensing fee is 6% so that Medicare Part B, Part D, and Advantage can be grouped together.

Computing the revenue lost requires information on the amount of Medicare spending on MDPNP drugs and the share of those expenditures that are 340B eligible. The most recent available data show that annual Medicare spending on the 2026 MDPNP drug cohort was $56.2 billion (CMS, 2024). 9.6% of Part D claims are 340B-eligible (Dickson et al., 2023). Assuming this percentage also applies to expenditures yields $5.4 billion of covered entity revenue. Since Medicare drug pricing is typically around WAC, I assume this number represents the WAC value. The average MFP discount relative to WAC is 63.1% for the 2026 cohort (CMS, 2024). Therefore, $5.4 billion of

[1] There is some nuance for physician-administered drugs for Medicare Advantage enrollees. While in-network coinsurance must be calculated on the basis of the MFP, the amount the plan pays the provider is the result of contractual negotiations. However, these rates will likely be negotiated down to the MFP (Smalldon, 2025).

WAC value translates to $1.99 billion at MFPs. New annual covered entity revenue equals MFP + 6%, or $2.11 billion – a loss of $3.29 billion.

When turning to 2027, one complication is that three drugs from the 2026 MFP cohort – Entresto, Xarelto, and Stelara – will exit the program at the start of 2027 due to the approval of generic/biosimilar competitors (National Community Pharmacists Association, 2025). Therefore, these drugs only affect revenue in 2026, meaning that estimating the contribution of the 2026 cohort to revenue losses in 2027 and beyond requires redoing the above calculations omitting them. This lowers annual Medicare spending on the cohort to $43.47 billion (CMS, 2024). This in turn leads to $4.17 billion of baseline covered entity revenue. Redoing the average MFP discount calculation yields 64.3%, lowering $4.17 billion to $1.49 billion. Adding 6% gives new covered entity revenue of $1.58 billion, for a loss of $2.59 billion.

For the 2027 MDPNP cohort, baseline Medicare spending is $40.7 billion (CMS, 2025a). Estimated covered entity revenue is 9.6% of this amount, or $3.91 billion. The average MFP discount to WAC for the 2027 cohort is 61.9% (CMS, 2025c), so $3.91 billion shrinks to $1.49 billion. New covered entity revenue is this amount plus 6%, or $1.58 billion – a loss of $2.33 billion. *Therefore, total revenue losses in 2027, during which 22 drugs will have MFPs, will be an estimated $4.92 billion. This is nearly five times the estimated 2027 cost reduction of $1.027 billion.*

IV. Indirect Effect on Covered Entity Revenues

With that said, the consequences of the MDPNP for covered entities do not stop with mechanical effects. General equilibrium effects from the resulting downward adjustment in commercial reimbursement rates will also be substantial. Since, as discussed above, commercial pharmacy contracts use a benchmark of AWP minus 16-18% (Fein, 2015) while AWP ≈ WAC × 1.20 (Aird and Counterman, 2026), any reduction in WAC will ultimately lead to a reduction in commercial reimbursement.

Manufacturers have an incentive to lower the WAC on MFP drugs. Under the MDPNP, pharmacies acquire and get reimbursed for negotiated drugs based on the WAC rather than the MFP at the point of dispensing. Manufacturers then reimburse pharmacies for the difference between WAC and MFP (Fein, 2025a). The manufacturer's net revenue is therefore the MFP regardless of the WAC, but the larger the spread, the greater the administrative burden from having to process rebates. If AWP minus 16-18% were a statutory, fixed formula, one could argue that the benefit to drug companies from leaving WACs higher could outweigh the cost from the heavier administrative burden. However, this formula is a convention rather than a rule. If drug companies did not initially lower their WACs for MDPNP drugs, PBMs could still use the new MFPs as leverage to negotiate lower rates. Accordingly, by January 2026, six of the ten drugs in the 2026 MFP cohort had lowered their list prices, as had two drugs from the 2027 cohort (Reinaud, 2026).

Quantifying this effect requires information on how much manufacturers lower the WAC when a drug enters the MDPNP, the percentage of a drug's volume billed to commercial insurers, and baseline expenditures on drugs in the program. The average reduction in WAC in January 2026 for the drugs in the 2026 cohort (excluding the three leaving the program in 2027) was 37.3% (Reinaud, 2026). No publicly available data exist on the breakdown of expenditures on MDPNP drugs by payer nationally, so I assume the mix is reflective of spending on all drugs, for which 39% comes from private insurance compared to 32% from Medicare (Fein, 2025b). Baseline Medicare expenditures for the drugs in the 2026 and 2027 cohorts (again excluding the three that are leaving the program) were $43.47 billion in 2023 and $40.7 billion in 2024, respectively (CMS, 2024, 2025a). For baseline expenditures on MFP drugs, I was able to find national FY24 expenditures from all payers for 13 of the 22 drugs, which total $38 billion (AbbVie Inc., 2025; Amgen Inc., 2025; AstraZeneca, 2025a, 2025b; Bausch Health Companies Inc., 2025; Bristol Myers Squibb, 2025; Eli Lilly and Company, 2024a, 2024b, 2024c, 2025; GSK plc., 2025; Pfizer Inc., 2025; Teva

Pharmaceutical Industries Ltd., 2025). For the other nine drugs, spending by Medicare alone totals $29.9 billion, implying expenditures from all payers of $93.3 billion based on the national Medicare share of 32% (Fein, 2025b). Therefore, estimated total spending on all 22 drugs is $131.3 billion.

From there, estimating covered entities' revenue lost is straightforward. Baseline expenditures on the 22 drugs in the MFP program by 2027 by commercial insurers is 39% of $131.3 billion, or $51.2 billion. Assuming Dickson et al.'s (2023) estimate of 340B accounting for 9.6% of Medicare drug fills applies to commercial insurance as well yields 340B-specific baseline revenue of $4.92 billion.[2] A 37.3% reduction in price received therefore comes to *$1.84 billion of losses from the indirect effect.*

Combining both direct effects and the indirect effect gives an estimate of the overall impact of the first two cohorts of MFPs on covered entity net revenue in 2027. With direct cost savings of $1.027 billion, direct revenue losses of $4.92 billion, and indirect revenue losses of $1.84 billion, the total effect comes to a loss of $5.73 billion. This represents almost 8% of the net revenue from the entire 340B program, estimated in Section II to be $71.9 billion.

V. Extrapolating Beyond 2027

Of course, new drugs will continue to be added to the MFP program annually – 15 in 2028 and 20 each year in 2029 and beyond. Since new, high-cost drugs are continually being introduced, there is no reason to expect the program to ever "run out" of drugs to add, meaning the direct and indirect effects on covered entities should continue to grow annually. There are, however, two caveats to this claim. First, since the MDPNP intentionally aimed to add the drugs with the highest Medicare expenditures first, the incremental losses added each year might become smaller over time as progressively less costly drugs are added – though the perpetual entry of newly approved,

[2] This estimate is consistent with HRSA's (2026b) claim that the 25 drugs in the 2026 and 2027 MFP cohorts (including the three that will be dropped in 2027) account for less than 5.5% of the $100 billion 340B program.

expensive brand name drugs into the program will limit the extent of this slowdown to some extent. Second, as already seen for the three drugs from the 2026 cohort discussed above, drugs will drop out of the MDPNP when a generic/biosimilar competitor enters. The following analysis aims to account for both of these phenomena.[3]

Since no prices have been announced for the 2028 cohort and neither the list of drugs nor their prices have been announced for 2029 and beyond, it is not possible to do calculations analogous to those done for 2026 and 2027 for these future cohorts. As a loose approximation, we can assume the dollar amounts from 2026 and 2027 generalize to future cohorts. The $5.73 billion in net covered entity losses across 22 drugs comes to $260 million per drug. Therefore, extrapolation yields an additional $3.9 billion in annual losses in 2028 once 15 more drugs are added and $5.2 billion for each subsequent cohort of 20 drugs. Critically, these amounts are *cumulative*: for instance, in 2029, the 2026, 2027, 2028, and 2029 drugs will all be in the program, so the predicted losses in the 2029 calendar year will come from *all four* cohorts, not just the 2029 cohort.

Pushing against this perpetual increase in annual losses is drugs from prior cohorts leaving the program when they face low-cost competition. However, with 20 new drugs entering the MDPNP each year, the rate of exit will be far slower than the rate of entry. New brand name drugs have an average of 13 years of market exclusivity between Food and Drug Administration approval and generic entry (Grabowski et al., 2021). This implies a steady-state exit rate of 8%.

To address the MDPNP adding the drugs with the highest Medicare expenditures first, I assume that the incremental effect of each additional cohort of drugs declines by 10% each year

[3] Another complication with long-run projections is that, in 2028, physician-administered drugs covered under Medicare Part B will be brought into the MDPNP for the first time, and reimbursement for these drugs is benchmarked to ASP rather than AWP/WAC (CMS, 2026a; MedPAC, 2025). Since prices for the 2028 cohort are not known, it is not possible to make a separate projection for these drugs. Therefore, I treat them the same way as drugs purchased at pharmacies and covered by Part D for the sake of these analyses. This should be a reasonable approximation, as ASP drops when the price falls for a segment of the market. If anything, ASP could conceivably fall more dramatically than WAC, as it is mechanically affected by a lower price for a subset of purchases, whereas WAC does not drop until manufacturers consciously lower it. This assumption should therefore be conservative.

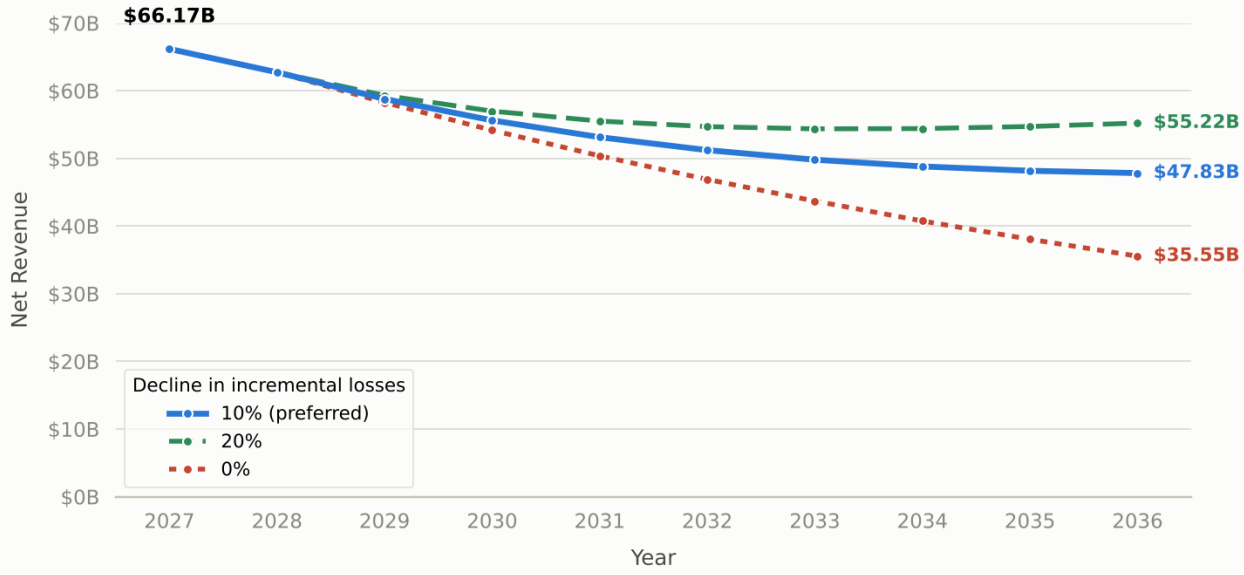
starting in 2029. I also consider 0% and 20% in sensitivity analyses. Using 0% essentially assumes that new high-cost drugs enter at a rate that offsets the declining cost of existing drugs entering the program.

In the previous subsection, I estimated annual lost net revenue in 2027 to be $5.73 billion. Lost revenue in 2028 starts with this same $5.73 billion but subtracting out the 8% from projected program exit to yield $5.27 billion. It then adds in the incremental effect of the 2028 cohort of 15 drugs, which – at $260 million per drug – comes to $3.9 billion. Total projected 2028 losses are therefore $9.17 billion. To compute 2029 losses, I start with this $9.17 billion less 8% and then add the incremental effect of the 2029 cohort of 20 drugs at 90% of $260 million per drug. This comes to $13.12 billion. Similarly, 2030 losses are $13.12 billion less 8% plus 20 drugs times 90% of 90% (i.e. 0.9^2 * 100%) of $260 million, which equals $16.28 billion. The pattern continues in successive years following the recursive series $L_{year} = 0.92 * L_{year-1} + 20 * \$260 \text{ million} * 0.9^{year-2028}$, where L_{year} represents the lost revenue in any given year.

Figure 1 shows how total covered entity net revenue from the 340B program will change over the next ten years under these assumptions. The middle curve – the solid blue line – depicts the scenario from the equation above, which features 10% annual declines in incremental losses. From its pre-MDPNP base of $71.9 billion, net revenue is predicted to fall to under $60 billion by 2029 and under $50 billion by 2033, ultimately stabilizing at just under $48 billion by 2036 – a 33% drop from baseline. The red dotted curve shows the sensitivity of these results to assuming no decline over time in the incremental losses from newly added drugs. Net revenue falls more sharply and linearly, reaching $35.6 billion (and still falling) by 2036. The green dashed curve uses a higher rate of decline of incremental losses of 20%. This leads to a smaller drop and quicker stabilization at roughly $55 billion. Importantly, even in this scenario, which is likely unrealistically favorable to covered entities, they will still experience around a 23% decline in net revenue relative to baseline.

Figure 1: Predicted Annual Covered Entity Net Revenue from the 340B Program

Under Alternative Assumptions About the Annual Decline in Incremental Losses



Estimates are given by subtracting annual losses from the MDPNP from baseline 2025 340B net revenue of $71.9 billion.

VI. Conclusion

The MDPNP gives the federal government the ability to negotiate the prices of a limited number of high-cost prescription drugs each year. The resulting MFPs can be either higher or lower than 340B prices, and covered entities are eligible for the lower of the two, lowering their costs. However, they also lose revenue from the statutory changes in Medicare reimbursement rates for MDPNP drugs and resulting renegotiated commercial insurance reimbursement rates. This study aims to quantify these factors and project how the MDPNP will affect covered entities' net revenues from the 340B program. Using preferred parameter values, I project an annual short-run net revenue loss of $5.73 billion that will grow to over $24 billion – 33% of total 340B net revenues – within ten years.

As is typical of calibration analyses, the estimates depend on a number of assumptions that are necessitated by limitations in available data. The exact numbers should therefore be interpreted with caution. With that said, the straightforward nature of the changes in payment rules makes the

main conclusion that the losses will become increasingly substantial as the MDPNP expands difficult to dispute.

There is considerable evidence that covered entities utilize at least some 340B funds to maintain or expand provision of services to vulnerable populations (Courtemanche and Garuccio, 2026). In a survey of over 1,300 hospitals, 95% reported using 340B savings to maintain or increase uncompensated care, 89% reported expanding services, and 80% reported offsetting Medicaid underpayment. When asked what they would cut if the 340B program shrunk, 75% said uncompensated care and 70% said services. Moreover, 75% of critical-access hospitals deem 340B savings essential to viability (340B Health, 2018). When manufacturers restricted contract-pharmacy pricing in 2020 and 2021, nearly all surveyed hospitals reported financial harm, with a substantial majority saying they would cut programs if the restriction expanded (340B Health, 2021). Although Desai and McWilliams (2021) did not find evidence of a statistically significant increase in uncompensated care following entry into the 340B program, Owsley and Bradley (2023) and Owsley et al. (2024) found 340B participation to be linked to hospitals adding oncology, psychiatric, substance-use, and obstetric services. With 417 hospitals in rural areas alone vulnerable to closure and 448 and 331 having dropped chemotherapy and obstetrics, respectively, in the last decade, such a dramatic drop in 340B net revenue would likely lead to closures of departments and potentially even entire hospitals (Chartis Center for Rural Health, 2026).

Adding to the concern are separate developments that also have the potential to substantially harm covered entity finances. First, CMS' proposed 2027 Outpatient Prospective Payment System (OPPS) rule would cut 340B Part B hospital reimbursement from ASP + 6% to ASP - 33.4%, based on the Medicare OPPS Drug Acquisition Cost Survey fielded in early 2026. CMS' fact sheet estimates a $4.55B reduction in Medicare drug payments (and therefore a corresponding reduction in covered entity revenue) in the first year. This would be implemented budget-neutrally through an

offsetting increase to non-drug OPPS payments, but this increase would be distributed across all OPPS hospitals, whereas the losses would be concentrated among covered entities (CMS, 2026b).

340B is also under attack from pharmaceutical manufacturers, which have aimed to stem the program's growth in several ways. First, they have imposed restrictions on the number of contract pharmacies, leading to a flurry of lawsuits and state legislation aimed at preserving these networks (Courtemanche and Garuccio, 2026). Next, they have begun requiring the usage of an industry-connected claims submission platform to improve detection of duplicate discounts, though covered entity representatives fear that the data will be used in other ways such as to deny valid claims (Courtemanche, 2026). Most recently, the drug industry has successfully lobbied the Health Resources and Services Administration (HRSA) for a rebate model to replace the usual upfront discounting for MDPNP drugs. While manufacturers contend that such a change is necessary to identify whether the 340B ceiling price or MFP should be used for fills, and to avoid duplication of discounts, covered entities fear that this could lead to substantial administrative costs and liquidity concerns (HRSA, 2026b).

Interestingly, despite their longstanding feud over 340B, the results from this study suggest that covered entity and manufacturer incentives are aligned with regard to MFPs. However, in contrast to the pharmaceutical industry's staunch opposition to the MDPNP (Sayki, 2023), covered entities have not publicly expressed opposition to the program's basic framework. Instead, they have focused lobbying efforts on the manner in which the MDPNP is implemented, particularly the rebate model (America's Essential Hospitals, 2026; Martin and Richardson, 2026; Verity 340B, n.d.). It seems conceivable that covered entities are not fully aware of the impacts projected in this study, both because they involve nuanced rather than highly visible policy details and because they accumulate slowly over time. It also seems possible that they have chosen not to fight an unpopular battle against a program designed to make drugs more affordable.

Regardless, the broader point made by this study is about policy tradeoffs. Improving the affordability of prescription drugs and reducing their fiscal burden is certainly a worthy policy objective. Nonetheless, one party's savings is another's lost revenue, and those losses have consequences that must be weighed against the benefits when evaluating the merits of any policy. Also, policies do not exist in a vacuum. One could acknowledge the downside of the MDPNP and still deem the program beneficial on net. In this case, other policies could be considered that would mitigate the downside by increasing funding of safety net health care providers through a different mechanism than drug sales. With the 340B program facing pressures from multiple directions, new ideas are likely to be necessary to ensure adequate access to health care for vulnerable populations moving forward.

Acknowledgments

I acknowledge support for this research from a grant from the Kentucky Hospital Association and a consulting agreement with Hall, Render, Killian, Heath & Lyman, P.C. Claude AI was used to assist with background research; the formatting of references, figures, and tables; and error-checking. The author is fully responsible for the content of this report, which did not require approval of the funders.

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