Health Capital Group White Paper

Grantee-Only Contract Pharmacy Mandates: Estimating the Potential 340B Economic Leakage from Overlapping Patients

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Abstract

Objectives

In 2024, federal grantees purchased $10.8 billion in 340B inventory with estimated gross reimbursement of $21.6 billion. For-profit middlemen, including contract pharmacies (CPs) and third-party administrators (TPAs) often owned by or affiliated with pharmacy benefit managers (PBMs), are playing an increasing role in the 340B program through relationships with 340B covered entities. Some state legislatures are considering CP mandates that prohibit manufacturers from putting limits on covered entities' ability to claim 340B discounts on drugs dispensed at CPs. In some states, these bills only prohibit limits on sales to CPs associated with grantees (grantee-only mandates). This study analyzes the economic impact of grantee-only mandates on the for-profit entities involved in the 340B program. We quantify patient overlap between grantee and hospital 340B entities, analyze differential drug spending patterns, and estimate economic implications of grantee-only mandates that could result in 340B drug reassignments from hospital covered entities (CEs) to grantee CEs. The findings also apply to any state or federal policy that would provide federal grantees greater flexibility than hospitals such as carve-outs of grantees from a 340B rebate model and/or claims data mandates.

Methods

We analyzed claims from 5.5 million lives from November 2019-November 2024 and identified whether care was received at a 340B covered entity for each encounter. We identified patients with 340B grantee visits and classified such patients as grantee-only or "overlappers" that were seen by both hospital and grantee covered entities. Overlappers were further defined as hospital-primary or grantee-primary based on visit patterns. We calculated drug spending and CP utilization rates, then we used HRSA purchase data to project the national economic impact of grantee-only CP mandates due to their resulting reassignment of CP drug fills of hospital-primary overlappers from hospital CEs to grantee CEs.

Results

There were 101,641 patients with 340B grantee visits. Among those patients, 72,186 (71%) also visited hospital-affiliated 340B sites (i.e., overlappers). If all drug fills from overlappers currently assigned to hospitals were reassigned to grantees due to grantee-only mandates (or other state or federal policies with a similar effect on drug fill assignments), the profits middlemen earn from grantees would triple to $5.6 billion annually. Assuming 20% annual program growth, cumulative transfers to for-profit entities from grantees could exceed $110 billion over ten years.

Conclusions

Substantial patient overlap, differential CP compensation structures, and a weak patient definition create conditions for grantee-only mandate bills to significantly increase the amount of 340B margins that goes to PBM-owned and affiliated for-profit entities. The scale of economic transfer to for-profit intermediaries raises fundamental questions about alignment between current program operations, potential changes, and the original safety-net policy intent.

I. Introduction

The 340B Drug Pricing Program was established in 1992 to help safety-net healthcare providers, known as covered entities (CEs), serve vulnerable populations by requiring pharmaceutical manufacturers to provide outpatient drugs at significantly discounted prices. When CEs dispense discounted 340B drugs to insured patients—including those with Medicare, Medicaid, Affordable Care Act (ACA) marketplace, or commercial insurance—they can generate substantial profits from the difference between the discounted acquisition cost and full reimbursement rates.

In 2024, federal grantees (e.g., federally qualified health centers (FQHCs), HIV clinics, hemophilia treatment centers, and STD clinics) treated over 32 million patients, representing just under 10% of the U.S. population.[1] Grantees purchased $10.8 billion worth of 340B inventory to sell to their affiliated patients, with an estimated reimbursement value of at least twice that amount based on typical 340B discounts and reimbursement rates.[2] The 340B program experienced continued expansion in 2024, posting 23% growth. Since 2020, the overall program has grown 20.1% per year. In 2024, the largest category of grantees (i.e., FQHCs) increased purchases by 34% from 2023, suggesting greater acceleration among grantees.[3]

Assuming 340B inventory is purchased at an average discount of 50% compared to eventual reimbursement,[4] gross 340B revenue for grantees was $21.6 billion in 2024. This substantial revenue stream has attracted the participation of numerous for-profit intermediaries, particularly contract pharmacies (CPs) and third-party administrators (TPAs), both of which are often owned by or affiliated with pharmacy benefit managers (PBMs), despite the program's intended focus on non-profit safety-net providers.[5]

A significant and growing portion of 340B prescriptions are filled at contract pharmacies rather than in-house pharmacies operated by CEs. These CPs—largely for-profit enterprises such as CVS and Walgreens—use sophisticated tools provided by TPAs to identify patients eligible for 340B discounted

drugs based on their treatment history at contracted CEs. These CPs and TPAs are typically affiliated with PBMs. In 2023 nearly 70% of CPs were associated with a PBM through vertical integration or contractual arrangement.[6] The economic arrangements between non-profit CEs and for-profit CPs, PBMs, and TPAs have historically been opaque, though recent mandatory state reporting requirements and Congressional oversight have begun to illuminate these relationships. According to the 2024 Minnesota 340B Annual Report, the median grantee CE pays 23% of gross 340B revenue to for-profit entities such as contract pharmacies, PBMs, and TPAs, while the median disproportionate share (DSH) hospital—by far the largest category of 340B purchaser—pays only 8%.[7] Assuming an average 340B discount of 50% relative to reimbursement, this implies that for-profit entities capture approximately 46% of program profits for grantee-affiliated prescriptions and 16% for hospital-affiliated prescriptions. These are significant amounts to which CEs no longer have access for any efforts to fulfill the original intent of the 340B program: helping vulnerable patients access their medicines.

Patients often receive care from both hospital-affiliated and grantee-affiliated 340B CEs. When these "overlapping" patients fill prescriptions at contract pharmacies that maintain relationships with both types of CEs, each 340B drug can be assigned to only one CE for purposes of claiming the 340B discount. This paper estimates the share of 340B patients whose 340B drug fills are likely assigned to a hospital CE but nevertheless have at least some connection - however tenuous - to a grantee CE. We demonstrate that this assignment decision has substantial economic implications for for-profit entities due to differential revenue-sharing arrangements between hospitals and grantees.

Our research reveals significant overlap in CP contracting patterns: 59% of CPs with a hospital contract also maintain at least one grantee contract, and 53% of those with a grantee contract also have a hospital contract. Pharmacies maintaining both types of contracts average 8 grantee contracts and 5 hospital contracts each. This extensive overlap, and a weak patient definition, creates the possibility that multiple CEs may be able to claim a CP client as their 340B patient.[8] When a patient appears at a CP with

contractual relationships to multiple CEs that have treated the patient, the affiliated TPA must apply a patient definition, which could be influenced by CP contractual terms, to determine which entity to assign the patient to for 340B purposes. Given the substantial difference in compensation between grantee-affiliated (23% of gross revenue) and hospital-affiliated (8% of gross revenue) prescriptions, CPs face strong financial incentives to assign patients to grantees whenever plausible.

Recent and potential changes in 340B policy have made patient reassignment from hospitals to grantees increasingly possible. The *Genesis* decision enjoined HRSA from enforcing its interpretation of patient definition requirements, potentially lowering the standard for what constitutes a qualifying patient relationship.[9] Additionally, ongoing efforts to pass state-level CP mandates that apply only to grantees would ban pharmaceutical manufacturers from placing any restrictions on contract pharmacy agreements between grantees and CPs. The same would not be true for agreements between hospitals and CPs. Therefore, manufacturers would be able to considerably limit, if not completely prevent, the number of 340B discounts claimed on drugs dispensed via contract pharmacy relationships with hospital covered entities. However, if a 340B hospital patient receiving a 340B-eligible drug from the pharmacy also has a relationship with a grantee, the TPA would be able to assign the dispensed 340B drug to the contract pharmacy relationship with the grantee. Thus, these grantee-only mandates, in effect, would result in new opportunities to shift current hospital-affiliated 340B prescriptions to be grantee affiliated when overlap exists.

This paper addresses three central questions:

1. What proportion of patients with grantee visits also have relationships with hospital-affiliated 340B entities?
2. How do drug spending patterns differ between hospital-primary and grantee-primary overlapping patients, particularly spending at contract pharmacies?

3. What is the potential economic impact for PBMs and other for-profit entities if, due to grantee-only CP mandates, overlapping patients currently affiliated primarily with hospitals were instead assigned to grantees when filling prescriptions at CPs?

While this analysis is framed around grantee-only mandates, the analysis findings are applicable to other reforms that provide grantees more flexibility relative to hospital covered entities. These reforms include a federal proposal to carve out community health centers from potential rebate models. Such reforms would result in similar shifts in current hospital-affiliated 340B prescriptions to grantee-affiliated 340B prescriptions and create incentives for hospital covered entities to expand their affiliations with grantees to access grantees' flexible terms and preserve profits. These affiliations and the weak patient definition will allow hospitals to associate their patients and 340B-eligible drugs with their grantees and bypass hospital-specific requirements. In 2022, approximately 21% of 340B hospitals had at least one grantee clinic registration and 7% of grantees were located within a 340B hospital. These affiliations would grow with the introduction of 340B reforms that provide grantees an advantage over hospitals.

II. Methods and Data

We analyzed anonymized medical and pharmacy claims data from HealthVerity Source 9 covering 5.5 million commercial and Medicaid managed care lives from November 2019 through November 2024.[10] The dataset includes comprehensive outpatient visit records, prescription fill records, and allowed charge amounts for both medical services and pharmacy claims. We supplemented the claims data with several external data sources:

340B Entity Files: HRSA's Office of Pharmacy Affairs maintains publicly available databases of registered 340B covered entities, including hospitals and federal grantees. We used these files to identify covered entity status and entity type.

Contract Pharmacy Data: We compiled contract pharmacy relationships from HRSA's public Office of Pharmacy Affairs Information System (OPAIS) 340B database, which lists all registered contract pharmacy arrangements by covered entity.[11]

National Provider Files: We used National Provider Identifier (NPI) and taxonomy code data from CMS to link claim records to specific provider types and organizational affiliations.

Pharmacy Identifiers: We used National Council for Prescription Drug Programs (NCPDP) identifiers to link prescription claims to specific pharmacy locations and determine their 340B contract pharmacy status at the time of dispensing.

Patient Identification and Classification

Our analysis proceeded in four steps:

Step 1: Grantee Patient Identification

We identified all patients in the dataset who had at least one outpatient visit to a 340B grantee site during the five-year study period. Grantee visits were identified using provider NPIs and taxonomy codes matched to entities registered as federal grantees in the HRSA 340B database. This included federally qualified health centers (FQHCs), HIV clinics, hemophilia treatment centers, STD clinics, family planning centers, and other eligible grantee types. We identified 101,641 patients with at least one grantee visit over the study period.

Step 2: Overlap Detection

For each patient identified in Step 1, we examined their complete utilization history across the five-year period to identify any visits to 340B hospital-affiliated outpatient sites. Hospital-affiliated sites included hospital outpatient departments, hospital-owned clinics, and other facilities owned by or formally affiliated with entities registered as DSH, children's, cancer, or rural referral center hospitals in the 340B program.

Of the 101,641 patients with at least one grantee visit, 29,445 had visits only to grantee CEs over the entire five-year study period. The remaining 72,186 patients (71%) also had at least one visit to a 340B hospital-affiliated site. We designated these patients with visits to both grantees and 340B hospitals as "overlappers."

Step 3: Primary Affiliation Assignment

We classified overlappers as either "hospital-primary" or "grantee-primary" based on where they had the majority of their outpatient visits over the five-year period. For each patient, we counted all outpatient visits to grantee sites and all outpatient visits to hospital-affiliated 340B sites. Patients with more hospital-affiliated visits were classified as hospital-primary; those with the same number of grantee and hospital visits or more grantee visits were classified as grantee-primary.

Of the 72,186 overlappers, 46,840 (65%) were hospital-primary and 25,250 (35%) were grantee-primary. For the analysis that follows, we assume that grantee-primary and grantee-only patients are the drivers of 340B drug spending attributed to grantees, with all 340B profits associated with the spending of hospital-primary patients going to hospital CEs.

Step 4: 340B Pharmacy Identification

We identified all pharmacies that filled prescriptions for patients in our sample and used HRSA's contract pharmacy database to determine whether each pharmacy was an active 340B CP for the relevant covered entity at the time the prescription was filled. We matched pharmacy NCPDP numbers to contract pharmacy registrations and verified the effective dates of each contractual relationship. For each patient category (i.e., grantee-only, grantee-primary overlapper, hospital-primary overlapper), we calculated the proportion of total allowed charges for prescription drugs that were dispensed at pharmacies with an active 340B CP relationship to a covered entity that

the patient had visited. We assume that prescriptions filled at a 340B CP are filled using 340B inventory.

Measuring Drug Spending

For each patient category, we calculated average annual allowed charges for prescription drugs in each year of the study period, with particular focus on 2024 data. Allowed charges represent the total amount insurers agreed to pay for prescriptions, including both insurer and patient responsibility amounts. This measure captures the revenue opportunity for 340B entities and their contract pharmacies before considering 340B discounts.

We separately calculated the proportion of each patient's drug spending that occurred at 340B contract pharmacies. For prescriptions filled at CPs, we assumed they were dispensed using 340B inventory, as contract pharmacies and their TPAs have strong incentives and sophisticated systems to maximize 340B utilization given their contractual arrangements.

Estimating For-Profit Entities' Revenue

To estimate total revenue flowing to PBM-affiliated for-profit entities from grantee-affiliated prescriptions, we combined our micro-level claims analysis with 2024 macro-level program data. We began with HRSA data showing that federal grantees purchased $10.8 billion worth of 340B inventory in 2024.[12] With an average discount of 50% relative to reimbursement, this implies gross 340B revenue for grantees of $21.6 billion in 2024. Using our 2019-2024 patient-level data, we calculated the share of total grantee-affiliated 340B spending attributable to different patient categories and the proportion occurring at contract pharmacies. We then developed scenarios to estimate the potential economic impact if grantee-only mandates had been in place and overlapping patients currently affiliated primarily with hospitals had instead been assigned to grantees when filling prescriptions.

III. Results

Table 1 presents our findings on patient overlap and spending patterns. The scale of patient overlap between grantee and hospital 340B entities is substantial. Among all 101,641 patients with at least one grantee visit during our five-year study period, 72,186 (71%) also had visits to hospital-affiliated 340B sites during the same period.

Table 1: Patient Categories and Drug Spending Patterns (2024)					
Category	**Number of Patients**	**Average Total Drug Spending**	**Average Spending at 340B CPs**	**% at 340B CPs**	**Total Spending at 340B CPs**
Grantee-Only	29,445	$2,065	$1,147	56%	$33.8M
Grantee-Primary Overlappers	25,250	$3,553	$1,029	29%	$26.0M
Hospital-Primary Overlappers	46,840	$4,524	$2,294	51%	$107.5M
All Grantee-Affiliated Patients (Weighted)	54,695	$2,752	$1,093	40%	$59.8M
All Overlappers (Weighted)	72,186	$4,184	$1,851*	44%	$133.6M

Source: Health Capital Group analysis of HealthVerity Source 9 Claims Data, November 2019 - November 2024

On average, each of the 72,186 overlapping patients generated $4,184 in total drug spending—more than twice as much as the grantee-only population. Hospital-primary overlapping patients have the highest total spending overall and filled the majority of their prescriptions at CPs. Hospital-primary overlappers spent 123% more at contract pharmacies than grantee-primary patients ($2,294 vs. $1,029).

The 29,445 patients who visited only grantee sites over the study period generated an average of $2,065 in drug spending in 2024, with $1,147 (56%) filled at 340B contract pharmacies. Grantee-primary overlappers generated $3,553 in drug spending of which 29% ($1,029) occurred at 340B CPs. Overall, presumed grantee-affiliated patients (those with at least one grantee visit and either no 340B hospital visits or a minority of hospital visits) generated $1,093 per capita in pharmacy spending at 340B CPs, representing 40% of grantee affiliated patient total drug spending. Note that grantee-primary overlappers represented 44% of the total grantee-affiliated 340B CP spending.

We use the total 340B purchases by grantees for 2024 as reported by HRSA and apply the percentages from our sample to estimate the dollar volume of grantee-affiliated spending through CPs nationally in 2024, as shown in Table 2.

Table 2: Distribution of Grantee-Affiliated Spending (2024)	
Total grantee 340B purchases (HRSA)	$10.8 billion
Estimated gross grantee 340B revenue (2x purchases)	$21.6 billion
Share of Grantee-Affiliated Spending at 340B CPs	40%
Gross Spending by Grantee-Affiliated Patients at 340B CPs	$8.6 billion
Current For-Profit CP/PBM/TPA revenue (23% of Spend at 340B CPs)	$2.0 billion

Source: Health Capital Group analysis

Per the HRSA data cited above, total grantee 340B purchases amounted to $10.8 billion in 2024, with associated gross revenue estimated at $21.6 billion. We estimate that 40% of that spending was through CPs, generating $2 billion in fees at the median grantee for profit entity payment rate of 23% in 2024.

Projected Impact of Grantee-Only Mandates

In 2024, only 19.5% of overlapper CP spending was generated by grantee-primary overlapping patients. As noted in Table 1, grantee-primary overlappers represented 44% of grantee-affiliated CP spending, and as shown in Table 2 we estimate total grantee-affiliated CP spending was $8.6 billion. Thus, we estimate that $3.8 billion of 340B spending was from grantee-primary overlapping patients. What would happen if states passed grantee-only mandates, only allowing manufacturers to restrict 340B sales to CPs associated with hospitals? We assume that CP spending by hospital-primary overlappers—currently attributed to hospital CEs — would instead be assigned to grantee CEs. If the remaining (hospital-primary) 80.5% of overlapper CP spending was reassigned to grantees, total grantee-affiliated overlapper CP spending would increase to $19.5 billion, assuming no changes to the underlying spending patterns for the patients. This represents a shift of $15.7 billion in CP spending from hospital-affiliation to grantee-

affiliation. That shift would increase the revenue of PBM-affiliated for-profit entities because PBM compensation rates are 15-percentage-points higher rates for grantees (23%) vs. hospitals (8%). The result would be an increase in for-profit intermediary 340B revenue of $2.4 billion annually. **Our estimates suggest that the shift in patient affiliation resulting from grantee-only 340B mandate bills would triple the profits middlemen earn from grantees to $5.6B**.

Under grantee-only contract pharmacy mandates, a limited number of hospital contract pharmacy relationships is likely to still exist. Thus, some hospital-primary overlappers are likely to continue to be assigned to hospital covered entities. Even if only 75% of the current 340B CP spending of hospital-primary overlappers were reassigned to grantees, the 340B revenue going to for-profit entities from grantees would more than double to a total of $4.7 billion.

Several important considerations should be noted. First, our claims data cover commercial and Medicaid managed care populations but do not include Medicare fee-for-service or uninsured patients, which may include additional opportunities for shifting between hospitals and grantees. Therefore, our analysis likely underestimates the true impact of grantee-only CP mandates. Second, we classify patients based on visit patterns, but actual 340B assignment decisions by TPAs may differ from this approach. Finally, when overlappers had an equal number of visits to hospitals and grantees, we assigned them to grantees. However, it is likely that a substantial portion of these patients were assigned by TPAs to hospitals. Thus, our model underestimates the number of reassignments in the case of grantee-only CP mandates. This means our estimates of additional costs are conservative.

IV. Additional Scenarios and Policy Implications

Our findings reveal a significant vulnerability in the 340B program structure. The combination of widespread patient overlap (71% of grantee patients also visit hospitals), differential CP compensation structures between hospitals and grantees, state-level grantee-only CP mandate bills and a weak patient definition creates conditions under which there could be substantial increases in 340B program revenue

that shifts from CEs, particularly grantees, to PBM-affiliated for profit entities without any change in patient assistance.

The magnitude of potential impact—$15.7 billion in reassigned drug spending and $2.4 billion in additional for-profit entity revenue—suggests this is not a marginal concern but rather a fundamental structural issue. Assuming tempered annual growth of 20% in 340B spending annually and projecting forward the potential shift in affiliation, grantee-only CP mandate bills would result in over $110 billion in cumulative revenue over the next 10 years for for-profit PBM-affiliated entities - funds that could instead be used to support patients. This is $62 billion more than the current projection without any changes to the program. This projection underscores the scale of potential economic leakage from the program if current trends toward relaxed patient definition standards, expanded grantee CP networks, and state-level policies exempting grantees from CP limits continue.

While this study focuses on a particular type of state legislation, its findings also provide insight into the impact of other state or federal legislation that are less restrictive for grantees. These include measures that prevent manufacturers from requiring grantees to submit claims data for their 340B units. For example, excluding grantees from a comprehensive nationwide rebate model would increase profits that middlemen earn from grantees by a similar amount.

Perhaps the most fundamental policy question concerns the role of for-profit entities in a program explicitly designed to benefit non-profit safety-net providers. The 340B statute generally requires participating entities to be non-profit or governmental organizations serving vulnerable populations. Yet our analysis suggests that for-profit intermediaries currently capture $2 billion annually from the grantee component of the program, with potential to nearly triple their take from grantees if grantee-only CP mandate bills are passed. Over a ten-year horizon and assuming modest 20% annual 340B growth, the cumulative transfer to for-profit entities could exceed $110 billion. This raises several questions for policymakers. First, is such a transfer to PBMs and other for-profit middlemen consistent with the

intended policy effects of 340B? Second, do these for-profit entities provide commensurate value through improved patient access and care coordination, or does this primarily represent rent extraction? Third, should there be limits on the share of 340B revenue that can flow to for-profit entities? Fourth, would direct subsidies to grantees be more efficient than the current indirect subsidy system routed through pharmacies?

While not the focus of this analysis, it should also be noted that the passage of CP mandate bills that apply to all CEs in states without any CP mandate could also lead to a substantial increase of 340B revenue for for-profit PBM-affiliated entities. Such mandates would block any existing manufacturer restrictions on hospitals and grantees claiming of 340B discounts at contract pharmacies, thus, allowing for an increase in the volume of 340B drugs that are filled at CPs. The resulting increase in for-profit revenues would not be as large as that from grantee-only CP mandates but nevertheless would be significant.

Conclusions

The 340B program has grown from a modest safety-net initiative to a program with gross reimbursement value approaching $200 billion. This scale demands commensurate attention to program integrity and alignment with policy intent. The potential for over $110 billion in cumulative transfers to for-profit middlemen over the next decade, driven by assignment discretion over overlapping patients, suggests the program has evolved far beyond its original design. Policymakers should carefully consider whether current program operations serve the intended beneficiaries or increasingly function as a revenue generation mechanism for healthcare intermediaries.

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