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How to Reduce Medicaid Cuts Using the 340B Drug Pricing Program

Gaby Hartney & David Kendall

Medicaid cuts are forcing states to make painful reductions in health care for working-class Americans. However, the federal government and states can blunt some of that harm by allowing state Medicaid programs to keep rebates from drug purchases that are currently lost when large hospitals participate in the 340B Drug Pricing Program.

Under current law, states have little control over how hospitals use 340B funds, and those dollars are not necessarily directed toward high-value services like primary care. At the same time, when hospitals purchase drugs through 340B for Medicaid patients, states forgo billions of dollars annually in Medicaid drug rebates that instead go to hospitals. Prioritizing Medicaid rebates over 340B discounts would help states preserve access to essential care as they navigate tight budget constraints.

This memo explains how Medicaid rebates and the 340B program interact, the financial impact on Medicaid programs, and reforms to better align 340B funds with the goal of making health care more affordable for working-class Americans.

The Problem: Higher Medicaid Costs Due to 340B

Medicaid loses billions of dollars each year when hospitals bill Medicaid for drugs purchased under the 340B program instead of the Medicaid Drug Rebate Program. Here's how to better understand that dynamic:

Two Overlapping Programs

In 1990, Congress created the Medicaid Drug Rebate Program in response to rising prescription drug costs in Medicaid. As a condition of Medicaid coverage, manufacturers must pay rebates to states, which then share those rebates with the federal government. For brand-name drugs, these rebates are calculated as either a minimum of 23.1% of the Average Manufacturer Price (AMP) or the difference between the AMP and the lowest price offered to any other health plan—whichever is greater. As a result, Medicaid beneficiaries see the lowest prices for prescription drugs, while state programs receive financial support.

At the time, pharmaceutical manufacturers were also voluntarily offering deep discounts to hospitals that served large numbers of uninsured and low-income patients. When Medicaid's new "best price" requirement threatened to eliminate those discounts, Congress responded by creating the 340B Drug Pricing Program in 1992. The purpose of 340B was narrow and clear: to preserve access to discounted drugs for true safety-net providers serving vulnerable populations.

In theory, this system allowed both Medicaid and safety-net providers to receive the lowest possible prices without overlapping. However, as the 340B program has expanded and Medicaid has evolved over the decades, this is not how it works in practice.

States, which largely administer their Medicaid programs, have broad discretion over how Medicaid drug payments interact with 340B. Further, Medicaid has shifted overwhelmingly into managed care, which now covers roughly three-quarters of all Medicaid beneficiaries. Managed care health plans have issues tracking which drugs hospitals and other providers purchase through 340B. As a result, many states cannot get managed care plans to bill for drugs through the Medicaid rebate program.

Program Interactions

When a 340B hospital dispenses an outpatient drug purchased under 340B to a Medicaid managed care enrollee, the state Medicaid program cannot use the Medicaid Drug Rebate Program because 340B prohibits duplicate discounts. Yet, Medicaid managed care payments do not incorporate the statutory rebates that protect Medicaid's lowest-price guarantee. As a result, Medicaid loses access to its rebates while hospitals profit from the spread between the 340B price and the managed care reimbursement rate.

This means Medicaid pays more for drugs dispensed by 340B hospitals than it would have paid if those drugs were dispensed outside the program. This costs Medicaid an estimated $2 billion to $6 billion in annual losses. These losses grow as the use of managed care in Medicaid increases and the 340B program continues to expand beyond its original safety-net footprint.

The impact is more pronounced in states with larger Medicaid managed care populations and extensive 340B hospital participation. Pennsylvania, Texas, Massachusetts, and other states are losing around $200 million in Medicaid rebates from 340B participation. Some states have blocked hospitals and other providers from billing Medicaid for drugs purchased through 340B, known as a carve-out. Thirty-eight states and Washington, DC, however, have not fully deployed this strategy.

Outlook

The 340B program is growing rapidly. It is the second largest drug-pricing program, larger than Medicaid and Medicare Part B drug purchases. At its current growth rate of roughly 20% annually, it is expected to surpass Medicare Part D and become the largest drug program. This growth will continue to amplify Medicaid's losses through rebates the program won't receive.

These financial losses for Medicaid will be even more acute in the near future. Federal Medicaid cuts from Republicans will reduce funding by nearly a trillion dollars over 10 years and threaten coverage for millions of Americans.

Beyond addressing cuts to Medicaid from the budget bill, federal lawmakers should rein in the 340B program to ensure that it meets the health needs of vulnerable communities—not undermine access to Medicaid.

The Solution: Put Medicaid First

Congress can take action to boost Medicaid funding by prioritizing Medicaid over 340B discounts to hospitals. This could be done through one of two reforms:

1. Require drugs reimbursed by Medicaid to be purchased outside the 340B program as some states have already done under a carve out. This would ensure 340B providers cannot increase costs for Medicaid to generate 340B revenues for hospital systems. This option would end all Medicaid payments for drugs at marked-up rates and allow the states and the federal government to claim the rebates to which they'd otherwise be entitled.
2. A scaled-down option would be to decrease reimbursement to 340B providers. 340B discounted prices are lower than typical reimbursement levels that include Medicaid rebates. Hospitals would still generate some 340B revenue from Medicaid patients. However, Medicaid would only receive a partial rebate (though their costs would be lower for 340B drugs compared to the status quo). In order to keep track of the different discounts, hospitals would need to participate in a federal rebate pilot program, which aims to have a clear accounting for each prescription and the corresponding discount.

Lawmakers could also consider limiting the scope of these solutions to apply only to non-rural hospitals and exempt non-hospital providers (like community health centers and other rural providers) from any losses. This would preserve resources from the 340B program for core safety-net providers that truly need it.

In addition to restricting Medicaid funding, the 340B program severely lacks accountability. Hospitals enrolled in 340B provide less in charity care compared to their for-profit and non-340B nonprofit counterparts. Addressing perverse incentives for the program would benefit vulnerable patients and federal health care programs.

The goal of these policies is simple: restore Medicaid's eligibility for rebates, recover billions of dollars annually for state and federal budgets, and use the savings to protect access to

care for Medicaid beneficiaries.

The Bottom Line

At a moment of historic cuts to the Medicaid program that will result in coverage losses for millions, lawmakers cannot afford to ignore a policy failure that siphons billions of dollars from the Medicaid program and vulnerable patients each year. Fixing 340B's drain on Medicaid would boost funding for the essential safety-net program and empower states to start negating the impact of the Medicaid cuts.