

340B Covered Entity Report

REPORT TO THE LEGISLATURE

February 27, 2026

340B Covered Entity Report: Report to the Minnesota Legislature, 2025

Minnesota Department of Health
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0975
health.rx@state.mn.us
www.health.state.mn.us/healtheconomics

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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The Honorable Tim O'Driscoll, Co-Chair, 2nd Floor, Centennial Office Building

February 2026

To the Honorable Chairs and Ranking Members:

As directed in Minnesota Statutes 62J.461 (https://www.revisor.mn.gov/statutes/cite/62J.461), the Minnesota Department of Health (MDH) collected and aggregated data from Minnesota health care providers that participate in the federal 340B Drug Pricing Program.

Enclosed is the second required legislative report analyzing and summarizing data from these providers—known as Covered Entities—on their 2024 participation in the 340B program. Consistent with the requirements in statute, the primary focus of this report is on the volume of net 340B revenue generated under the program. The reporting does not include information on how net 340B revenue is used nor to what extent patients are benefiting, and reported data are not audited nor otherwise verifiable. This report also does not include an assessment of the impact to other areas of the health care system.

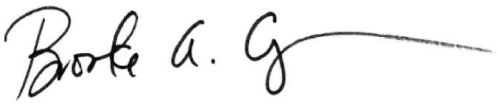
The findings from this nation-leading initiative continue to provide much needed transparency to the 340B program. After a modification to statute in 2024, this year's reporting more fully includes all 340B drugs—both pharmacy-dispensed drugs and office-administered drugs—and these data therefore provide a much more complete depiction of statewide net 340B revenue than was shown in the first

report. MDH determined that Minnesota Covered Entities generated a **collective net 340B revenue of at least $1.34 billion** for calendar year 2024. However, due to Covered Entities' challenges reporting on office-administered drugs, this figure is likely still an undercount by an unknown amount.

This report is available online: 340B Covered Entity Report Publications - MN Dept. of Health (https://www.health.state.mn.us/data/340b/reports/index.html).

Questions or comments on the report may be directed to Stefan Gildemeister, the state health economist, at (651) 201-4520, or health.Rx@state.mn.us.

Sincerely,



Brooke Cunningham, MD, PhD
Commissioner
P.O. Box 64975
St. Paul, MN 55164-09

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Executive summary

The federal 340B Drug Pricing Program (340B) is an initiative aimed at supporting safety net health care providers under which qualified providers—known as Covered Entities—can purchase outpatient drugs at discounted prices from manufacturers with no limit on the reimbursements that Covered Entities receive from insurers or other payers. In an environment of high and rising drug costs, this means that by participating in the program, Covered Entities can generate revenue or, for some providers, reduce their losses. Annual drug purchases under the 340B program nationally totaled $66 billion in 2023 and $81 billion in 2024.[1] There are currently no direct federal or state requirements on how Covered Entities use revenues generated under the 340B program.

In 2023, Minnesota was the first state to pass legislation to collect and report data from participating 340B providers. These results were a first-in-the-nation view of net 340B revenues. Prior to Minnesota's 2024 340B Covered Entity Report to the Legislature, little was known about the magnitude of the program, how much revenue entities generated, and through which payers' revenues were generated.

The findings from the first report—including that Minnesota Covered Entities generated at least $630 million from the program—were a significant step forward in 340B transparency in terms of understanding the program's size within the state. However, the data in the first report to the Legislature largely did not contain data on office-administered drugs—such as infusions and injectable drugs—and therefore was considered a substantial undercount of statewide 340B net revenue. The Legislature addressed the issue and this second report on 340B activity more fully includes both pharmacy-dispensed and office-administered drugs. Therefore, this 2025 report to the Legislature provides the most complete view of the size of the 340B program and the associated costs within Minnesota to date.

Notably, the Legislature did not task the Minnesota Department of Health (MDH) with assessing impacts of the 340B program on the health care system—such as service provision, prescribing patterns, manufacturer prices, or interactions with other programs—nor how Covered Entities use net 340B revenues.

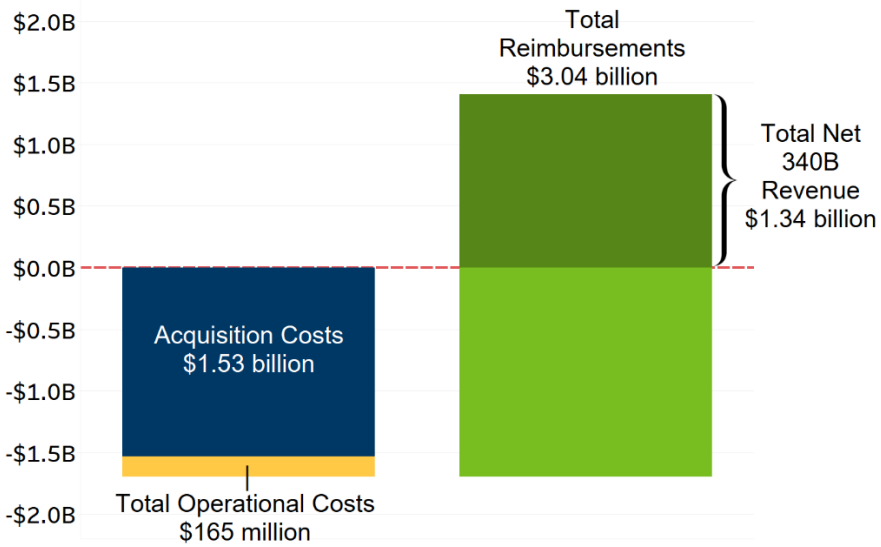
Key findings

Based on the second year of reported data, MDH determined that Minnesota Covered Entities earned a collective net 340B revenue of **at least $1.34 billion for the 2024 calendar year**. This net revenue figure is over twice the reported net 340B revenue for the 2023 calendar year—which was $630 million. While the significant increase likely does capture *some* program growth, the increase is *primarily* due to the more complete inclusion of office-administered drugs by Covered Entities in this year's data submissions. This year's reporting provides a much more comprehensive depiction of the annual costs of drug acquisition and program operation and net revenues in the state. However, MDH believes the $1.34 billion of net 340B revenue is likely still an

[1] 2023 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases); 2024 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2024-340b-covered-entity-purchases).

underestimate due to challenges in capturing office-administered drugs. Figure 1 summarizes statewide net 340B revenue and its components in Minnesota for 2024.

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.

Many distinct health care provider types participate as Covered Entities in the 340B program—from general acute care hospitals and Critical Access Hospitals to disease-specific and safety net clinics—and the reported data reveal notable variations between these provider types as well as reinforce patterns first observed in the 2023 data.

- The state's **largest 340B hospitals continued to generate the largest revenue from the 340B program**. These hospitals reported generating over $1 billion in net 340B revenue—over 80% of statewide net 340B revenue.
- Conversely, **Safety Net Federal Grantee clinics—which include Federally Qualified Health Centers (FQHCs), their lookalikes, and tribal health centers—generated the least net 340B revenue**.
- Additionally, there was significant variation in revenues generated between Covered Entities within the same entity type.

Submissions also included more robust data for 2024 on how much it costs Covered Entities to run 340B programs. **Total operational costs were approximately $165 million**. This includes external costs (including payments made to contract pharmacies and third-party administrators) and internal costs (including staffing and other administrative expenses incurred by Covered Entities). Together, these data provide the most complete view of the costs of operating 340B programs. For every collective $100 of gross 340B revenue generated, Covered Entities paid approximately $12 to administer and operate their 340B programs.

Conclusion

The second year of data reporting for the Minnesota 340B Covered Entity Report represents an important step forward in transparency for the 340B program by providing a more complete picture of the size of the program

in Minnesota, both in terms of total net 340B revenue and total operational costs. Despite this improved perspective on program size, challenges surrounding the accurate reporting of office-administered drugs suggest 2024 net 340B revenue may still be an undercount. Moreover, while the findings in this report are a considerable step forward in clarifying the magnitude of the program in Minnesota, they do not extend to how Covered Entities use these resources in support of safety net functions. Increasing 340B transparency and understanding in Minnesota would require additional steps to be taken by the Legislature.

This report also includes a set of key questions stakeholders are seeking to better understand regarding program size, use of net 340B revenues, and incentives generated by the program across the health care system.

Introduction

The federal 340B Drug Pricing Program (340B) is an initiative aimed at supporting safety net health care providers under which qualified providers—known as Covered Entities—can purchase outpatient drugs at discounted prices from manufacturers with no limit on the reimbursements that Covered Entities receive from insurers or other payers. In an environment of high and rising drug costs, this means Covered Entities can generate revenue or, for some providers, reduce their losses through their participation in the program. Annual drug purchases under the 340B program nationally totaled $66 billion in 2023 and $81 billion in 2024.[2] There are currently no direct federal or state requirements on how Covered Entities use revenues generated under the 340B program.

The 340B program has evolved significantly since it was originally established in 1992 and has grown particularly quickly in the past 10 years.[3] The Health Resources and Services Administration (HRSA), the federal agency that administers the 340B program, reported that drug purchases through the 340B program—referred to hereafter as 340B drugs—increased by over $12 billion in 2023 nationally and by another $15 billion in 2024, which represent annual increases of greater than 22% each year.[4]

Despite its size and significance, the 340B program has not been well understood and continues to lack large-scale transparency. Minnesota's reporting initiative has provided a first-in-the-nation view of program size, volume of net revenue, and distribution of net revenue across providers and payer markets in which these revenues were realized. While a significant step forward in generating transparency about the 340B program, the Minnesota Department of Health's (MDH) first report in 2024 noted that important questions remained on how these revenues are used, who benefits most, and to what extent financial incentives distort prescribing patterns.

Both federal and state policymakers have been focusing on increasing transparency and oversight of the program recently. Proposals have aimed to reform how the program operates, and states continue to expand reporting on net 340B revenue, how these revenues are used, and contract pharmacy arrangements. Overall, these efforts reflect ongoing attention to the 340B program and its implications for Covered Entities. (See Appendix 5 for additional information regarding the 340B policy landscape.)

This report contains data from the second iteration of data reporting in Minnesota. Data include 340B transactions that took place in calendar year 2024. The data from calendar year 2023 and summarized in last year's report to the Legislature largely did not contain data on office-administered drugs—such as infusion and injectable drugs—and therefore did not present a complete picture of the state's 340B revenue landscape. The 2024 Legislature addressed this issue and most submissions in 2025 contained both pharmacy-dispensed and

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[2] 2023 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases); 2024 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2024-340b-covered-entity-purchases).

[3] For additional background on the 340B program, see Appendix 3 of the 2024 340B Covered Entity Report (https://www.health.state.mn.us/data/340b/docs/2024report.pdf).

[4] 2023 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases)

office-administered 340B drugs. The 2025 Report to the Legislature, therefore, provides a more complete understanding of the size of the 340B program and associated costs within Minnesota.

Notably, the Legislature did not task MDH with assessing impacts of the 340B program on the health care system—such as service provision, prescribing patterns, manufacturer prices, or interactions with other programs—nor how Covered Entities use net 340B revenues.

Statutory background and reporting overview

The Minnesota 340B Covered Entity Report (Minnesota Statutes, chapter 62J.461) was established by the Legislature in 2023 for annual data reporting beginning in 2024.[5] The statute directs MDH to:

- Specify and communicate the form and manner for reporting.
- Receive data from Covered Entities.
- Aggregate results in an annual report to the Legislature.

After a modification by the Legislature, the statute now makes it explicit that the scope of data reporting includes both pharmacy-dispensed and office-administered 340B drugs. The statute now also includes a provision to ensure that the annual report includes a list of net 340B revenue by Covered Entity for entities with a significant share of total Minnesota net 340B revenue, as defined by MDH (see Appendix 6).

Administered drug data

In general, office-administered drugs—hereafter called administered drugs—are drugs administered in outpatient settings that require a health care professional to assist in their administration. They are mostly injectable or infusion drugs (e.g., oncology or cancer medications and treatments for blood, neurological, or autoimmune disorders). Administered drugs are often significantly more expensive than pharmacy-dispensed drugs—hereafter called dispensed drugs. Capturing accurate data on administered drugs is essential to understanding the full scope of the 340B program. In the first year of reporting, most Covered Entities only reported data on dispensed 340B drugs—excluding administered drugs—due to ambiguity in the legislation. The Legislature clarified its intent to collect data on *all* 340B drugs—including administered drugs—and reports submitted in 2025 were required to completely include both types of 340B drugs.

In addition to differences in delivery method and cost, administered drugs are also tracked and billed through separate channels from dispensed drugs and can sometimes be difficult to separate from other services.[6] In preparation for collecting administered drug data, MDH conducted interviews with a representative sample of Covered Entities who shared the challenges with extracting administered drug data. Despite Covered Entities

[5] The program was originally established in Minnesota Statutes, chapter 62J.312, subd. 6 (https://www.revisor.mn.gov/statutes/cite/62J.312#stat.62J.312.6). It was amended in 2024 and is now under Minnesota Statutes, chapter 62J.461 (https://www.revisor.mn.gov/statutes/cite/62J.84).

[6] Administered drugs are typically billed under an insured patient's medical benefit, and dispensed drugs are typically billed under an insured patient's pharmacy benefit.

being required to submit actual reimbursement[7] data, MDH responded to stakeholder input by providing guidance that allowed many Covered Entities to submit partial or full estimates of their reimbursements for administered 340B drugs if they were unable to submit actual reimbursement data.[8] (See Appendix 4 for more information on data quality and limitations.)

Not only is capturing data on administered drug reimbursements essential to understanding the size of the 340B program, but it is also essential to understanding drug spending more broadly. Prescription drugs represent one of the fastest growing areas of health care spending, and administered drugs are a significant driver of this—both in 340B and elsewhere.[9] The inability to accurately trace reimbursements for administered drugs extends beyond 340B—meaning it is currently impossible to fully understand how much Minnesotans are collectively paying for administered drugs, and therefore prescription drugs in their entirety.

Reporting

The data reported by Minnesota Covered Entities to MDH and aggregated in this report include several data elements that summarize each entity's 340B transactions for the 2024 calendar year (see Appendix 3 for a description of data elements, calculated fields, and payer types). Only Covered Entities operating as parent entities are directed to report, however their submissions are required to contain information for their associated child sites.[10]

To be eligible for the 340B program, providers cannot operate as a for-profit and must meet the requirements for at least one of the Covered Entity types outlined in Section 340B(a)(4) of the federal Public Health Service Act. Broadly, these Covered Entity types include safety net hospitals, hospitals with a disproportionate share of low-income patients, and grantees that provide targeted clinical services (see Appendix 2 for a more detailed list and the groupings used in this report). Some Minnesota providers do not qualify for 340B or do not participate and were therefore not required to report under this initiative—notable examples include Mayo Clinic Rochester and Park Nicollet Methodist Hospital.

MDH identified 204 Covered Entities in Minnesota required to report in 2025 and received submissions from 198 Covered Entities for an overall response rate of 97%. This compares to an overall response rate of 94% last year. MDH considers this an extremely successful response rate for the second year of reporting, stemming in part from strong collaboration between Minnesota providers and MDH. The entities that did not report were smaller

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[7] The required data element *Payments received* includes all payments for 340B drugs, including insurance reimbursements, cost sharing (copayments and coinsurance), cash payments, and any other payment forms. For simplicity, the term "reimbursement(s)" refers to *Payments received* in this report.

[8] Reporting Administered 340B Drug Data in 2025 (https://www.health.state.mn.us/data/340b/docs/admindrug2025.pdf)

[9] Conti RM, Turner A, Hughes-Cromwick P. Projections of US Prescription Drug Spending and Key Policy Implications. JAMA Health Forum. 2021;2(1). Available at Projections of US Prescription Drug Spending and Key Policy Implications | Health Policy | JAMA Health Forum | JAMA Network (https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776040).

[10] "Parent" Covered Entities are the primary entity designated by HRSA; "child sites" or "grantee-associated sites" are affiliated outpatient facilities that participate under the parent's eligibility.

grantee clinics—many no longer in operation—and MDH does not expect their absence to meaningfully affect findings. There were 17 entities that submitted reports to MDH indicating no 340B transactions despite being listed as active 340B Covered Entities; these submissions were excluded from analysis.[11] Table 1 summarizes Covered Entity reporting and their inclusion in this report's data summary and analysis by grouping (see Appendix 2 for more detail on Covered Entity groupings).

Table 1: Summary of 2025 Minnesota Covered Entity reporting

Major Entity Type	Covered Entity Grouping	Expected to Report	Reported	Sufficient Data to Include in Analysis
Hospital	General Acute Care Hospitals (DSH)	23	23	23
Hospital	Critical Access Hospitals (CAH)	73	73	70
Hospital	Other Hospitals	9	9	9
Grantee	Disease-Specific Federal Grantees	80	74	63
Grantee	Safety-Net Federal Grantees	19	19	16
	Total	**204**	**198**	**181**

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

Data quality

Although the second-year reporting rate was excellent and all entities certified their reported data, MDH identified data quality issues in over half of all Covered Entity submissions. MDH worked with each of these entities—in some cases over a period of several months—to ensure quality data was submitted. Note that all

[11] MDH reached out these Covered Entities for clarification and often found that the Covered Entities were no longer active, no longer administering or dispensing drugs, or otherwise did not make any 340B purchases in 2024.

information was self-reported by each reporting entity rather than obtained through an external audit process and therefore could not be independently verified.

MDH identified three major data challenges with second-year reporting:

1. Widespread inconsistency in reporting the number of 340B drugs (units) dispensed or administered.
2. Challenges reporting reimbursements for administered drugs.
3. Inconsistency in reported internal costs.

See Appendix 4 for additional summary of data quality issues.

Scope of the 340B program in Minnesota

While 204 parent Covered Entities were required to report 2024 data, the reach of many of their 340B programs is *much* larger. Through contract pharmacies and child sites, Covered Entities expand their service areas and patient base, thereby growing the scope of their 340B programs. For example, a Covered Entity may designate outpatient sites[12] as 340B child sites, which may be in locations near or far from the parent Covered Entity. Child sites may provide 340B drugs to eligible patients on behalf of the parent Covered Entity, thereby increasing the volume of 340B drugs it provides *and* increasing the opportunity to generate net 340B revenues. Covered Entities may also contract with pharmacies to dispense 340B drugs to reach more patients, likewise, generating opportunity for greater revenues.

Using the HRSA Office of Pharmacy Affairs Information System (OPAIS)[13] online database, MDH identified 1,172 unique child sites associated with the 204 Minnesota parent sites eligible to purchase and distribute discounted 340B drugs in 2024.[14] These 204 parent sites additionally have 2,472 contractual agreements with pharmacies, of which only about half are located in Minnesota. Table 2 lists the number of Minnesota-based parent Covered Entities, the number of associated child sites, and the number of contractual agreements with outpatient pharmacies by Covered Entity grouping. Some pharmacies may have contracts with multiple Covered Entities. Minnesota Covered Entities hold 1,284 *contracts* with pharmacies based in Minnesota, however, these contracts are only with 574 unique pharmacies—indicating an average of over two contracts with Covered Entities per

[12] Outpatient facilities include hospital-owned and operated clinics or departments that provide services such as cancer and infusion centers, ambulatory surgery units, primary and specialty care clinics, imaging and diagnostic centers, behavioral health programs, and rehabilitation or therapy services. Most child sites are associated with hospitals rather than federal grantees.

[13] HRSA Office of Pharmacy Affairs Information System (OPAIS) (https://340bopais.hrsa.gov/home)

[14] This figure excludes 116 child sites located in Minnesota but whose associated parent Covered Entity is not located in Minnesota and sites otherwise not expected to report.

contract pharmacy. Of the community-outpatient pharmacies located in Minnesota, MDH found approximately 60% had at least one 340B contract with a Minnesota Covered Entity.[15]

Table 2: Count of Minnesota-based Covered Entities, child sites, and contracts with outpatient pharmacies

Covered Entity Groupings	Parent Covered Entities Expected to Report	Associated Child Sites	Contracts with Outpatient Pharmacies
General Acute Care Hospitals (DSH)	23	761	840
Critical Access Hospitals (CAH)	73	109	497
Other Hospitals	9	245	354
Disease-Specific Federal Grantees*	80	0	319
Safety Net Federal Grantees	19	57	462
Total	**204**	**1,172**	**2,472**
% of total located in Minnesota	**100%**	**99.5%**	**51.9%**

Source: MDH, Health Economics Program analysis of data from HRSA OPAIS, October 2025.

[15] Pharmacies are designated as "community-outpatient" based on their licensure with the Minnesota Board of Pharmacy. The "community-outpatient" designation includes traditional retail pharmacies and specialty pharmacies.

Findings

Overview of Covered Entity reporting

Based on the second year of reported data, MDH determined that Minnesota Covered Entities earned a **collective net 340B revenue of at least $1.34 billion** for the 2024 calendar year.[16] This net revenue figure is more than twice the reported net 340B revenue for Minnesota Covered Entities for the 2023 calendar year—which was $630 million. While trends show the 340B program has been growing significantly—national data indicated greater than 22% year-over year growth in 2023 and 2024[17]—and the increase likely does capture *some* program growth, the increase in net 340B revenue is *primarily* due to the inclusion of administered drugs in Covered Entities' submissions for 2024 compared to minimal reporting on administered drugs for 2023.

This report presents a more complete depiction of the annual program costs and revenues in Minnesota than the first year; however, MDH believes that 2024 statewide net 340B revenue likely remains an undercount of the full amount accruing to Covered Entities. This undercount likely stems from the widespread inability of Covered Entities to fully identify reimbursements for administered drugs. The $1.34 billion in net 340B revenue includes $64 million that Covered Entities estimated they were not able to account for in their submissions.[18]

Figure 1 summarizes the relationship between costs—both acquisition[19] and programmatic costs—and reimbursements for 340B drugs that make up the $1.34 billion in net 340B revenue. Note an assumption for this figure is that without the 340B program, there would be no net revenue margin on outpatient drugs (meaning that reimbursements equal non-340B acquisition costs). Although this is likely not the case, identifying an

[16] This value is the difference between the reimbursements for 340B drugs ($3.04 billion) and the sum of the cost of acquiring those drugs ($1.53 billion) and the internal and external costs of administering their 340B programs ($165 million).

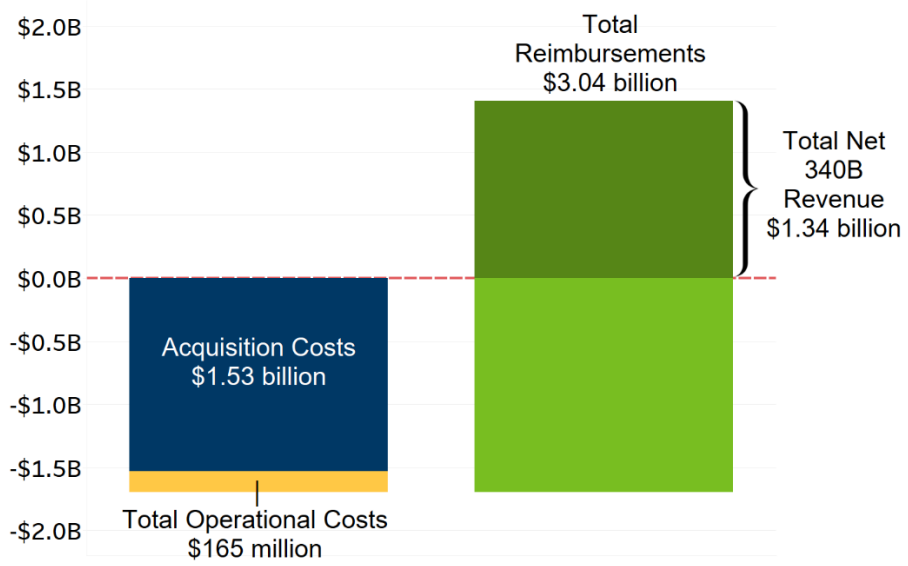
[17] 2023 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases); 2024 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2024-340b-covered-entity-purchases)

[18] Covered Entities that submitted administered drug data using an alternative estimation method were expected to provide MDH with their estimation of the percent of reimbursements missing or unaccounted for, which is what MDH used to calculate the $64 million adjustment. However, it is likely that the $64 million amount does not fully capture all administered drugs reimbursements. Appendix 4 provides additional information on data quality issues including the challenges associated with reporting on administered drug reimbursements and costs.

[19] The acquisition cost is based on the 340B discount, which is set in federal statute. Sometimes Covered Entities purchase 340B drugs at an additional discount known as a sub-ceiling discount.

alternative "non-340B margin" would require knowing the 340B discount for each drug product[20] and the non-340B prices offered by group purchasing organizations or other purchasing streams.[21]

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.

Impact of the inclusion of administered drug data

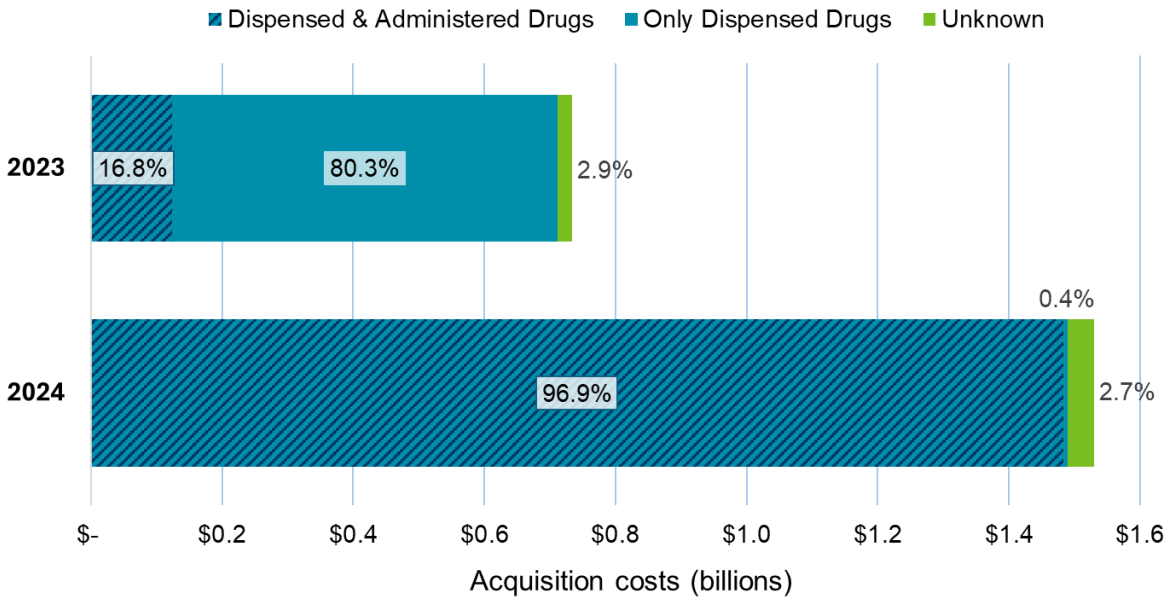
Last year, few reporting entities included administered 340B drug data in their submissions. The issue was rectified by the Legislature, and this year Covered Entities were required to submit data including all dispensed and administered 340B drugs. Both this year and last year, MDH conducted a follow-up survey with each Covered Entity that reported to understand the scope of their reporting. Based on these survey results, submissions fell into three categories: those that included only dispensed drugs; those that included both dispensed and administered drugs; and those which MDH could not determine the scope of drug reporting due to failure to participate in the survey (see Appendix 4 for more on data limitations). Figure 2 displays the total *acquisition costs* of drugs purchased under the 340B program by year, distributed by which types of drugs were included in submissions. Reported acquisition costs in 2023 were $734 million and largely excluded administered drugs; reported acquisition costs were $1.53 billion in 2024 and predominately included both dispensed and

[20] Previous estimates from the federal Office of Inspector General [Part B Payments for 340B Purchased Drugs (https://oig.hhs.gov/reports/all/2015/part-b-payments-for-340b-purchased-drugs)] place most 340B discounts between 25% and 50% of wholesale acquisition cost; however, some 340B drugs are purchased at near 100% discounts due to a practice known as "penny pricing."

[21] Group purchasing organizations (GPOs) are entities that help multiple organizations—such as hospitals, clinics, or pharmacies—leverage their collective purchasing power to obtain better prices, terms, and services from suppliers and manufacturers.

administered drugs. The significant increase between this year and last year in reporting on both dispensed and administered drugs—a percentage point increase of 80%—underscores that the inclusion of administered drugs in 2024 is primarily responsible for the increases in net 340B revenue and administered drugs are a considerable component of 340B programs.

Figure 2: Total reported 340B acquisition cost by scope of reporting, 2023-2024



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

Findings by Covered Entity groupings

There are a variety of 340B Covered Entity types in Minnesota that reflect the range of distinct criteria that make health care provider entities eligible to participate in the 340B program (see Appendix 2). Factors affecting Covered Entities' net 340B revenue include the services they provide, drugs they prescribe, differences in the patients they serve, and operational decisions—including the use of contract pharmacies or inclusion of child sites. See Appendix 6 for a listing of the Covered Entities with the largest shares of statewide net 340B revenue.

Table 2 summarizes net 340B revenue and its components by Covered Entity grouping. Net 340B revenue shows significant variation across entity types with large hospitals that qualify under the 340B program's Medicare Disproportionate Share Hospital (DSH) designation generating by far the largest net revenues—as a group and per hospital. This grouping, which includes many of the state's largest non-profit and public general acute care hospitals [hereafter referred to as General Acute Care Hospitals (DSH)], accounted for only 12% of the reporting entities but represented over 80% of the statewide net 340B revenue. Conversely, Safety Net Federal Grantees—which include Federally Qualified Health Centers (FQHCs), so called FQHC-lookalikes, and tribal

health centers—generated the least net 340B revenue with less than 1% of the statewide total. These results are similar to last year's findings.[22]

The variation in net 340B revenue is also driven by different reimbursement structures for Covered Entities. When a Covered Entity receives a market rate reimbursement for a 340B drug—such as an insurance reimbursement or cash payment—it will generally generate net 340B revenue (that is, revenue received exceeds the acquisition cost). However, if a Covered Entity provides a 340B drug for free or at a reduced rate—a requirement for FQHCs that serve a high number of low-income or uninsured patients—it may lose money even at the discounted rate. This means that rather than generating revenue, some 340B entities experience a net loss even at the reduced prices the 340B program provides—though likely a smaller net loss than without 340B. Table 2 aggregates all entities within a grouping together, and the losses of some are offset by the net revenues of others. There were 15 Covered Entities (seven hospitals and eight grantees) that reported 340B transactions but generated $0 or less in net 340B revenue.

[22] 2024 340B Covered Entity Report (https://www.health.state.mn.us/data/340b/docs/2024report.pdf)

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.

As noted, the increase in net 340B revenue observed between 2023 and 2024 data is primarily due to the addition of administered drugs in the most recent reporting after being largely excluded in 2023. Table 4 displays both 2023 and 2024 net 340B revenue by Covered Entity grouping as well as the percentage increase for each grouping. Increases in net 340B revenue varied considerably between hospitals and grantees, likely due to differences between their service delivery models, patient populations, and use of administered drugs. The over 100% increase in reported net 340B revenue across all hospital groupings indicates that administered drugs likely contribute to at least half of hospital net 340B revenue. Conversely, few grantee Covered Entities deliver administered drugs, contributing to the smaller year-over-year change.

Table 4: Change in reported net 340B revenue by Covered Entity grouping, 2023-2024

Covered Entity Grouping	2023 Net 340B Revenue	2024 Net 340B Revenue	% Increase in Net 340B Revenue
General Acute Care Hospitals (DSH)	$505,744,881	$1,082,379,896	114.0%
Critical Access Hospitals (CAH)	$59,624,576	$135,437,811	127.2%
Other Hospitals	$36,303,924	$92,301,794	154.3%
Disease-Specific Federal Grantees	$20,731,659	$22,007,925	6.2%
Safety Net Federal Grantees	$7,857,313	$8,143,538	3.6%
Total	**$630,262,352**	**$1,340,270,964**	**112.7%**

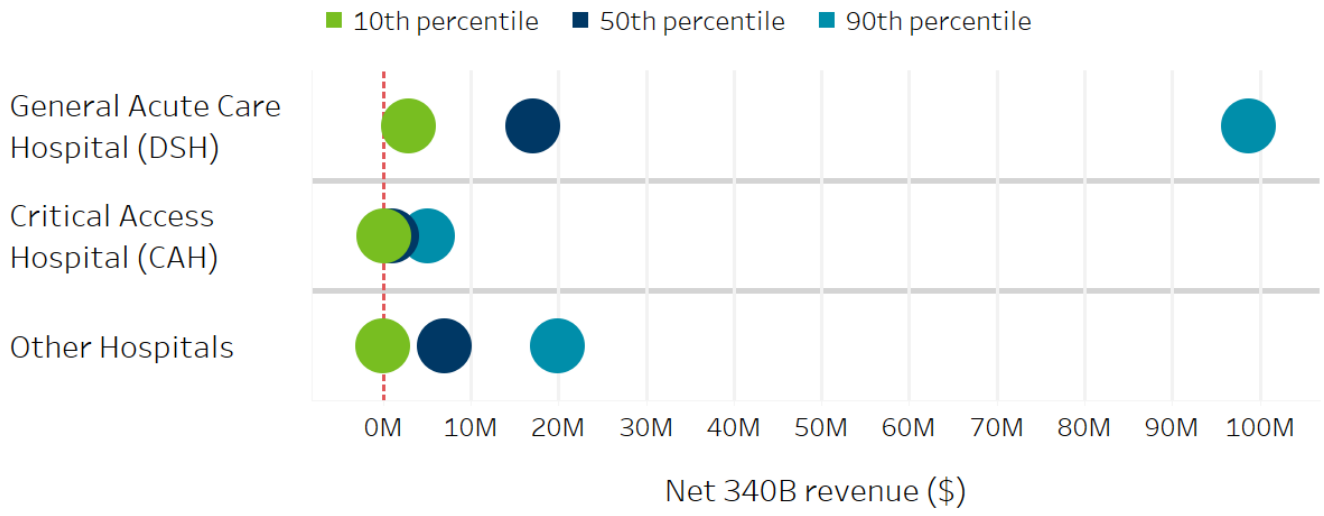
Source: MDH, Health Economics Program analysis of 2024 data reported by Covered Entities under the Minnesota 340B Covered Entity Report.

While the magnitude of net 340B revenue varied across Covered Entity groupings, there was also significant variation between entities within groupings. The variation between entities within the same grouping is strongly associated with the size of the facility, in terms of both the number of beds and child sites. Figures 3 and 4 show the variation in net 340B revenue by grouping for hospitals and grantees, respectively. These figures use the statistical concept of percentiles to show how individual values relate to others in a group: the 90th percentile indicates that 90% of Covered Entities within that grouping generated less net 340B revenue than the

corresponding amount while the remaining 10% of Covered Entities within that grouping generated the corresponding amount or greater in net 340B revenue.

The wide interval between the 10th and 90th percentile for General Acute Care Hospitals (DSH) in Figure 3 indicates substantial variation in net 340B revenue across these facilities. Although the *average* net 340B revenue is approximately $47 million per General Acute Care Hospital (DSH) (see Table 2), the *median* net 340B revenue is approximately $17 million, meaning that half of these entities generated $17 million or less. The top 10% of General Acute Care Hospitals (DSH)—or those at or above the 90th percentile—generated nearly $100 million or more in net 340B revenue, raising the average significantly (see Appendix 6 for a list of net 340B revenue by entity for select entities). The top 10% of Critical Access Hospitals (CAH) and DSH Hospitals generated approximately five times more net revenue than the bottom 50%, while the top 10% of Other Hospitals generated more than three times as much net revenue than the bottom 50%. The bottom 10% of Other Hospitals reported negative net 340B revenues.

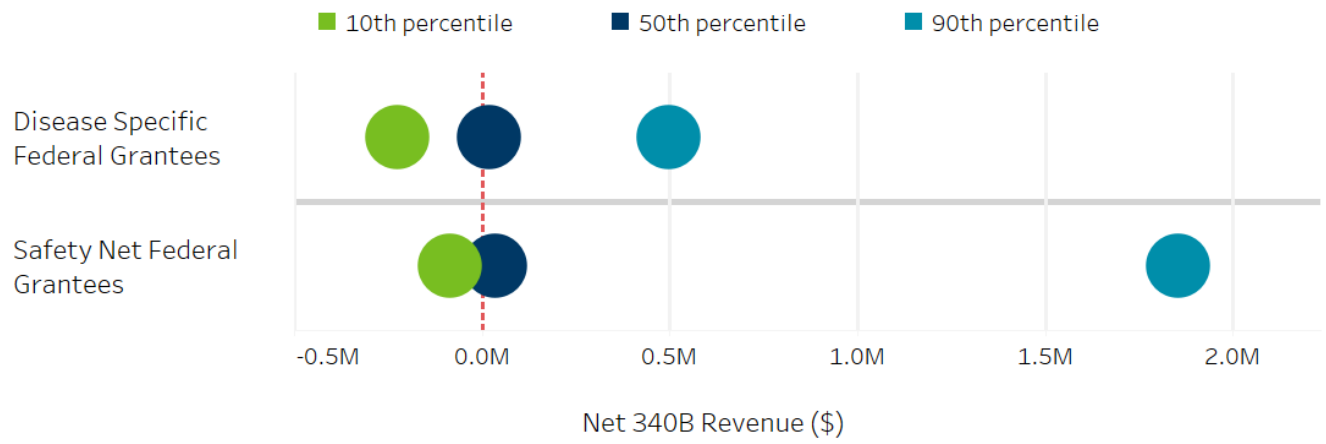
Figure 3: Net 340B revenue distribution by hospital type, 2024



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

Figure 4 shows there is significant variation between grantees as well, but in general the 340B program appears to play a different role for these Covered Entities. Despite some grantee entities generating significant net 340B revenues, 340B more broadly acts to reduce losses rather than generate net revenue for grantees. Fifty percent of both Disease-Specific and Safety Net Federal Grantees generated less than $40,000 in net 340B revenue, with the bottom 10% of each reporting negative net 340B revenues.

Figure 4: Net 340B revenue distribution by grantee type, 2024



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

Cost of operating 340B programs

Although 340B provides the opportunity for Covered Entities to generate net revenues or reduce losses, Covered Entities incur significant costs operating their 340B programs.[23] For some entities, these operational costs—which may either be internal to the entity or for external services—may determine whether their 340B program operates at a loss or not. Submitted data include total *contract pharmacy* costs, *other external* costs (such as payments to third party administrators), and *internal* costs—these fields provide the most complete known picture of the operating costs of participating in a 340B program. (See Appendix 4 for data limitations related to internal costs.)

In 2024, Covered Entities reported collectively paying approximately $165 million in *total operational costs*. About $137 million of this was in contract pharmacy ($120 million) and other external costs ($17 million), representing nearly 10% of total statewide gross 340B revenue.[24] In other words, for every $100 dollars of gross 340B revenue generated, Covered Entities collectively paid approximately $10 to *external* organizations—such as contract pharmacies and third-party administrators. The remaining approximately $28 million went towards internal costs for administering their 340B programs.

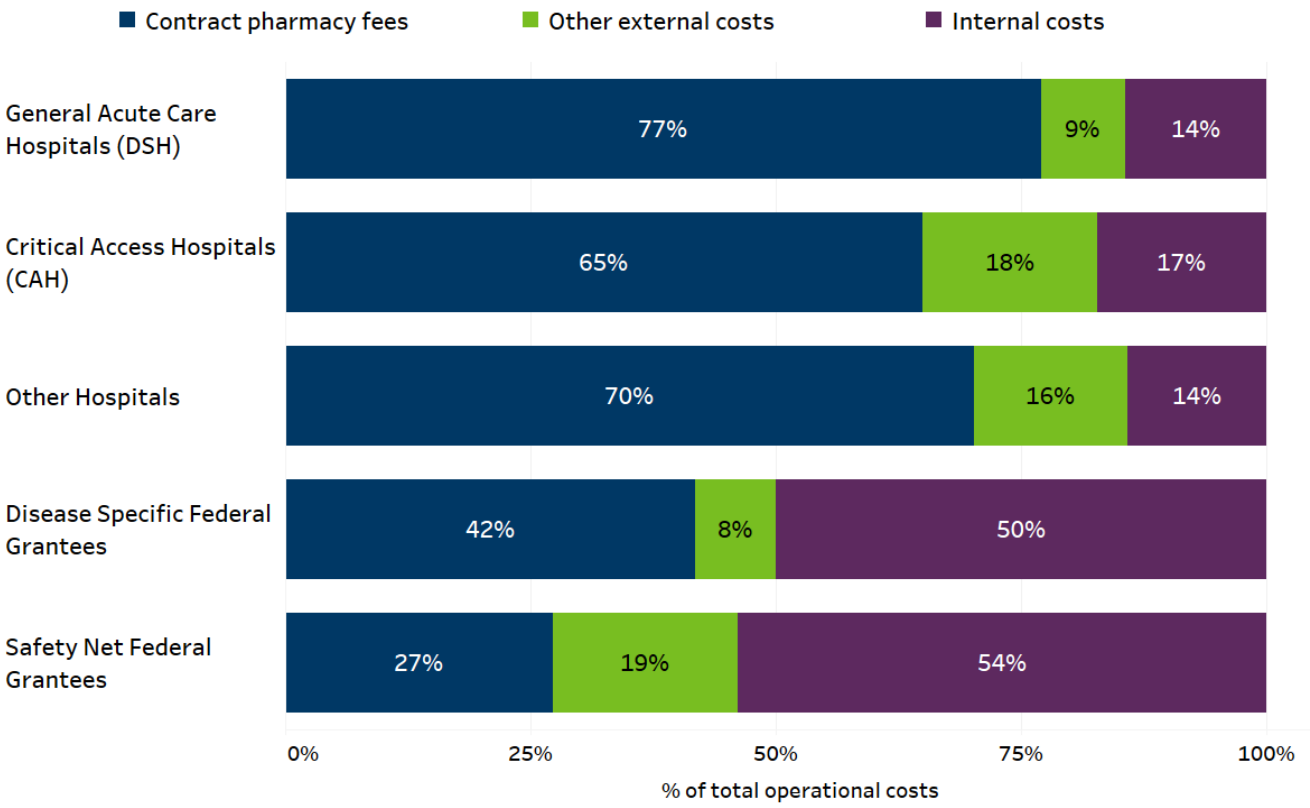
Figure 5 displays the operational cost categories as a percentage of total operational costs by Covered Entity grouping. The relative contribution of each cost category varies considerably—but expectedly—by Covered

[23] For reporting on 2024 data, the 340B Covered Entity Reporting statute was modified to require reporting on the internal and external costs directly related to administering a Covered Entity's 340B program, in addition to the existing requirement to report payments made to contract pharmacies.

[24] Total payment to contract pharmacies was required in both years and remained essentially the same between 2023 and 2024: approximately $120 million.

Entity grouping. Contract pharmacy fees accounted for approximately 70% of hospital Covered Entity costs but 42% or less of grantee Covered Entity costs. Conversely, internal costs collectively make up less than 20% of hospital Covered Entity costs but 50% or more of grantee Covered Entity costs. This pattern is primarily because contract pharmacy fees are tied to drug volume and the size of a Covered Entity's contract pharmacy network, whereas internal and other external costs are likely relatively fixed. Hospital Covered Entities generally prescribe a greater total volume of drugs than grantees, resulting in greater fees paid to contract pharmacies

Figure 5: Distribution of 340B operational costs by category and Covered Entity grouping, 2024



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

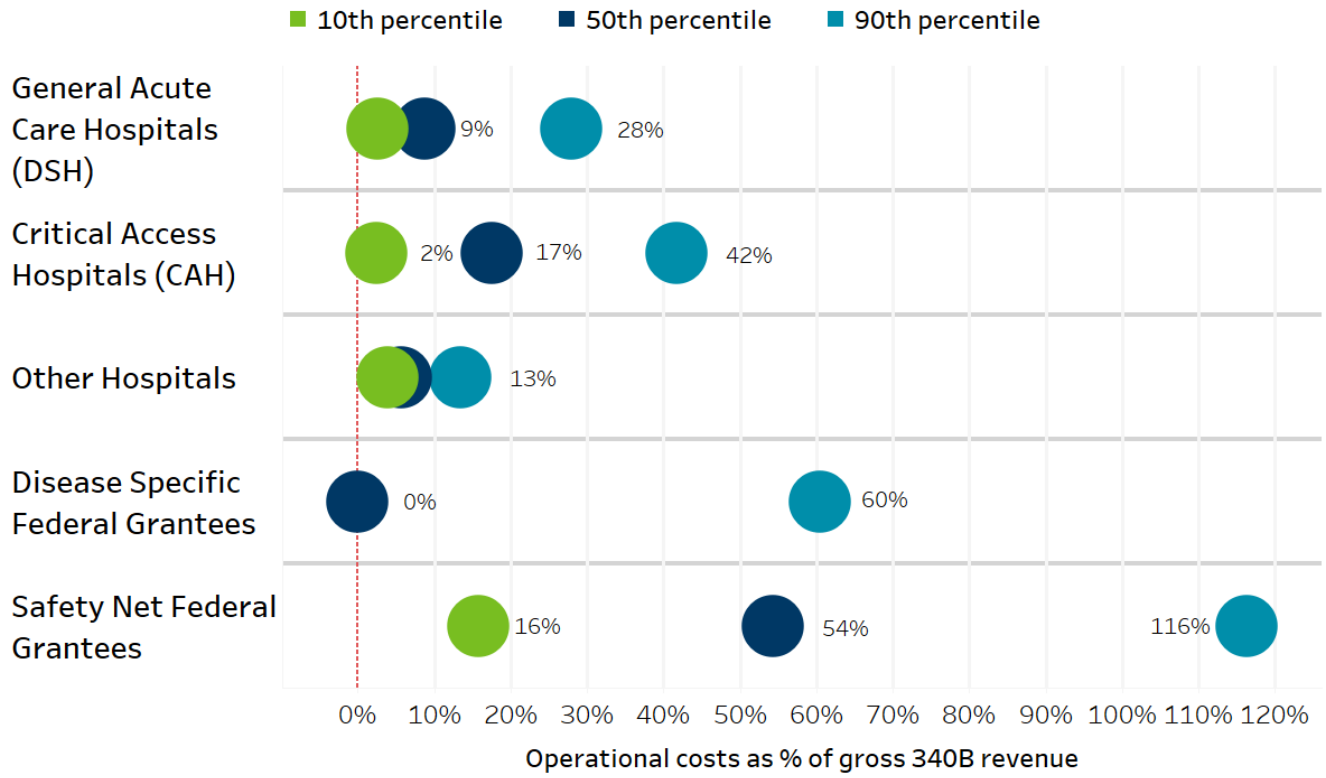
Total operational costs as a percentage of gross 340B revenue also varied considerably between Covered Entity groupings—see Figure 6.[25] This variation is primarily because grantee Covered Entities tend to provide a lower volume of drugs and generate lower gross 340B revenue compared to hospitals as drugs may frequently be provided to patients for free or at reduced rates. The costs of running a 340B program are generally fixed for grantees, and relative to smaller or nonexistent revenue margins operational costs are high. The top 10% (the 90th percentile) of all hospitals had total operational costs ranging from 13% (Other) to 42% (CAH) of gross 340B

[25] Twenty-one entities with gross 340B revenue less than $10,000 were excluded from this analysis. Most of these Covered Entities belong to the Disease Specific Grantee grouping.

revenue, whereas the top 10% of grantee Covered Entity groupings had total operational costs of 60% or greater of their gross 340B revenue.

Most dramatically, the top 50% of Safety Net Federal Grantees spent at least 54% of their gross revenue on operational costs. In other words, for every $100 generated through the 340B program after accounting for acquisition costs, $54 went to operations such as program administration, staffing, contract pharmacies, and third-party administrators.

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.

Findings by payer type

Covered Entities were not required to submit their 2024 data on acquisition costs by payer type, therefore calculating net 340B revenue by payer type is not possible.[26] MDH estimated net 340B revenue by payer type for 2024 by applying the ratio of reimbursements to net 340B revenue from 2023 data to 2024 statewide net 340B

[26] See *Payer types* in Appendix 3.

revenue—see Table 5.[27] Although the mix of administered and dispensed drugs differs between the two years, this estimate nonetheless provides an approximation of net 340B revenue by Covered Entity groupings and payer type in 2024 that is in line with total statewide net 340B 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.

[27] MDH excluded the *Other* payer type due Covered Entities submitting very different types of data in this category between 2023 and 2024. MDH also rounded the results of this calculation to the nearest million dollars.

Drug-level findings

The Minnesota 340B Covered Entity Report requires hospitals to report on their 50 most frequently dispensed or administered drugs under the 340B program, which are reported at a drug product—or national drug code (NDC)—level. Volume data was limited for 2024 and operational cost data (e.g., contract pharmacy fees) are not reported at the drug level, so MDH can only report on gross 340B revenue.[28]

MDH found notable concentration in these top hospital-reported 340B drugs: a small number of drugs account for a significant portion of total drug acquisitions and a small number of drugs—many brand-name and administered drugs—drive gross 340B revenues. These data suggest that certain drugs have disproportional potential for 340B revenue—so much so that the program may incentivize prescribing patterns, influence service decisions, and may contribute to increases in overall health care spending.

Collectively, the hospital-reported 50 most frequently dispensed or administered 340B drugs generated $185 million in gross 340B revenue, accounting for approximately 12% of statewide gross 340B revenue. The drugs that generated the largest gross 340B revenue were primarily "specialty drugs." While there is no standardized definition of a specialty drug, they are generally characterized by their high cost, often purchased through specialty channels, often administered, and used to treat chronic conditions including cancer or autoimmune diseases. Many of these drugs are designated as biologics by the Food & Drug Administration (FDA).[29] In 2024, the top three drugs[30] by gross 340B revenue were, in order:

1. Trikafta (elexacaftor-tezacaftor-ivacaftor), a treatment for cystic fibrosis that is dispensed and generated 1.76% of statewide gross 340B revenue.
2. Humira (adalimumab), a treatment for autoimmune disorders that is primarily dispensed and generated 1.74% of statewide gross 340B revenue.
3. Keytruda (pembrolizumab), a cancer drug that is administered and generated 1.35% of statewide gross 340B revenue.

Collectively, these three drugs generated $73 million in gross 340B revenue or nearly 40% of the $185 million in gross 340B revenue generated from all "top 50" drugs reported by hospitals.

Despite lacking *net* 340B revenue data by drug in 2024, *gross* 340B revenue figures indicate that high-cost specialty drugs and administered drugs are significant drivers of hospital 340B revenues. Additionally, 2023 data showed that the net 340B revenue *per prescription fill* for dispensed drugs often totaled in the hundreds or thousands of dollars—potential net revenues for administered 340B drugs, which were primarily excluded in 2023, are likely even higher. The significant opportunity to generate net 340B revenue from administered drugs

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[28] For pricing units (volume), some entities reported on the number of claims while others reported on the number of pricing units (e.g., gram, milliliter, etc.). See Appendix 4 for more detail.

[29] Food & Drug Administration. (November 2024) Biological Product Definitions (https://www.fda.gov/files/drugs/published/Biological-Product-Definitions.pdf)

[30] Drug is defined here as all drug products within the same drug family (see Appendix 1) that are produced by a single manufacturer.

and specialty drugs suggests that 340B could be influencing additional areas—such as prescribing patterns, service offering decisions, and other factors that may affect overall health care spending. See Appendix 7 for additional analysis of drug-level data.

Conclusion

Since the inception of the 340B program—a program created to strengthen the health care safety net in an environment of high and rising drug costs—it has lacked transparency. However, recent initiatives have paved the way for increased transparency and oversight aimed at better understanding the size of the program and how revenues are used to support safety net care provision. Minnesota's 340B Covered Entity Report continues to be at the forefront of these state-led efforts.

This second-year report is a significant step forward in capturing the size of the 340B program in Minnesota, the variation of costs and revenues across Covered Entities, the role of intermediaries, the role of specialty drugs in generating revenues, and the distribution of net revenue across payer types. Reporting this year indicates Covered Entities in the state generated **at least $1.34 billion in net 340B revenue in 2024**. This figure includes data on both dispensed and administered drugs and is in line with expectations after the first year of reporting. MDH believes this year's net 340B revenue estimate continues to be somewhat of an undercount due to challenges in obtaining accurate and complete data on administered drugs.

While Minnesota's understanding of 340B has advanced considerably, some important questions raised by stakeholders remain unanswered:

- How do Covered Entities use net revenues generated through the 340B program?
- To what extent do revenues reach patient populations, and which communities benefit the most?
- What actions can be taken at the state level to assist safety net providers with limited financial resources and who face significant operational costs in administering the program?
- For context, what are the net revenue margins for Covered Entities on non-340B outpatient drugs purchased through group purchasing organizations?
- To what degree, if any, does participation in the 340B program influence prescribing patterns, drug utilization, and overall health care spending?
- Do drug manufacturers pass on the cost of forgone revenue associated with 340B discounts by raising drug prices across the board?
- What factors have contributed most to the growth of the 340B program, and to what extent can their individual impacts be measured?

While this Minnesota 340B initiative is an important step towards greater understanding of how safety-net services are supported, transparency on its own cannot resolve the broader complexities of the current health care financing system. However, this reporting effort provides policymakers and other key stakeholders with a valuable tool to support informed, intentional decision-making—helping them pursue meaningful improvements while maintaining stable support for the outcomes they aim to preserve and avoiding unintended consequences.

Acknowledgements

MDH recognizes and appreciates the dedicated work of staff at Minnesota Covered Entities who collected, prepared, and submitted data, and who responded to MDH inquiries.

This work was made possible by the many informal conversations MDH had with national experts on billing for office-administered drugs.

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Appendix 1: Acronyms & glossary

Acronyms

CMS – Centers for Medicare and Medicaid Services

DSH – Disproportionate Share Hospital

FDA – Food & Drug Administration

FQHC – Federally Qualified Health Center

GPO – Group Purchasing Organization

HRSA – Health Resources and Services Administration

MDH – The Minnesota Department of Health

MHCP – Minnesota Health Care Programs

NDC – National Drug Code

OPAIS – Office of Pharmacy Affairs Information System

TPA – Third-Party Administrator

Glossary

340B discount: The price reduction that applies to outpatient drugs purchased by Covered Entities participating in the 340B program. The 340B discounted price is set in federal statute and is referred to as the "ceiling price."

340B drug(s): Outpatient drugs purchased at discounted prices and dispensed in retail settings or dispensed to a provider and administered in an outpatient setting. 340B Drugs do not include inpatient drugs.

Child site: An off-site outpatient facility under the management of a parent 340B Covered Entity that can administer or dispense the Covered Entity's 340B drugs to patients on behalf of the parent.

Contract pharmacy: A pharmacy that dispenses a Covered Entity's 340B drugs to the Covered Entity's patients that is not part of the Covered Entity. Contract pharmacies are off-site retail pharmacies (e.g., CVS, Walgreens).

Covered Entity: A hospital or clinic eligible and approved by HRSA to participate in the 340B drug discount program under Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. § 256b(a)(4).

Drug families: Groups of one or more drug products that share a unique generic product description, nontrade name, and dosage form.

Group purchasing organizations (GPO): Organizations that help collections of other entities—such as hospitals, clinics, or pharmacies—leverage their collective purchasing power to obtain better prices and terms on drug acquisitions.

Health Resources and Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services and the entity responsible for administering the 340B Drug Pricing Program.

National Drug Code (NDC): The three-segment code maintained by the federal Food and Drug Administration that includes a labeler code, a product code, and a package code for a drug product.

Office-administered drugs: Drugs dispensed to a provider and administered to patients in a clinic or other outpatient setting. These are often injection or infusion drugs such as chemotherapy medications.

Outpatient Pharmacy Administration Information System (OPAIS): A database maintained by HRSA to record information on eligible Covered Entities, their contract pharmacies, and child sites.

Pharmacy-dispensed drugs: Drugs distributed to patients directly from a pharmacy.

Pricing unit: The smallest dispensable amount of a prescription drug product that could be dispensed or administered (e.g., gram or milliliter).

Reporting Entities: Parent 340B Covered Entities in Minnesota required to report under the Minnesota 340B Covered Entity Report statute. The parent Covered Entities are required to include data for all child and associated sites and any other entity doing business on their behalf related to 340B.

Appendix 2: Covered Entity groupings

MDH grouped HRSA-designated 340B Covered Entity types into groupings that were used for analysis. Appendix Table 2 provides 340B Covered Entity types and definitions and the corresponding categories used by MDH. Although HRSA lists 16 Covered Entity types, there are some types that do not have any providers in Minnesota such as Black Lung Clinics and Freestanding Cancer Hospitals.[31] Appendix Table 2 only includes Covered Entity types in Minnesota.

Appendix Table 2: Covered Entity grouping crosswalk

340B Covered Entity Type	Entities in Minnesota (count)	Description	Covered Entity Grouping	Major Covered Entity Grouping
Comprehensive Hemophilia Disease Treatment Center	3	Hemophilia Treatment Centers receive federal grants to care for individuals with hemophilia and other bleeding disorders. This category includes both hospitals and non-hospitals.	Disease-Specific Federal Grantee	Federal Grantee
Children's Hospital	2	Nonprofit hospitals that serve individuals through the age of 18 years of age and certified children's hospitals by CMS. 340B children's hospitals must also provide a minimum amount of inpatient care to Medicaid and low-income Medicare patients. These hospitals became eligible for 340B participation under the Affordable Care Act of 2010.	Other Hospital	Hospital
Critical Access Hospital	73	Critical Access Hospitals are designated by CMS. They must have less than 25 beds and are generally located in rural areas. These hospitals became eligible for 340B participation under the Affordable Care Act of 2010.	Critical Access Hospital	Hospital

[31] Health Resources & Services Administration. 340B Eligibility (www.hrsa.gov/opa/eligibility-and-registration)

340B Covered Entity Type	Entities in Minnesota (count)	Description	Covered Entity Grouping	Major Covered Entity Grouping
Disproportionate Share Hospital (DSH)	23	Disproportionate Share Hospitals are general acute care hospitals that receive Medicare DSH payments and are designated based on a calculation that includes Medicaid and Medicare inpatient stay days, hospital size, and geographic location. DSH entities can be nonprofit, for-profit, or public hospitals, but for-profit entities cannot participate in 340B.	General Acute Care Hospitals (DSH)	Hospital
Health Center Program Award Recipient	15	These are Federally Qualified Health Centers (FQHCs), which are community-based health care providers designated by CMS and receive funds from the federal government to provide primary care services in underserved areas.	Safety Net Federal Grantee	Federal Grantee
Health Center Program Look-Alike	3	These are community-based health care providers that meet the requirements to be an FQHC, but do not receive federal funding.	Safety Net Federal Grantee	Federal Grantee
Rural Referral Center	1	These are high-volume acute care rural hospitals.	Other Hospital	Hospital
Ryan White HIV/AIDS Program Grantee	9	A health care organization that receives federal funding to provide HIV/AIDS treatment and related services to people living with HIV/AIDS who are uninsured or under-insured under the Ryan White Act. These Covered Entities may include hospitals or non-hospitals.	Disease-Specific Federal Grantee	Federal Grantee

340B Covered Entity Type	Entities in Minnesota (count)	Description	Covered Entity Grouping	Major Covered Entity Grouping
Sexually Transmitted Disease Clinic	65	Clinics that diagnose and treat sexually transmitted diseases and receive funding from their state and local health departments through the federal Sexually Transmitted Disease Control Program administered by the Centers for Disease Control and Prevention.	Disease-Specific Federal Grantee	Federal Grantee
Sole Community Hospital	6	Sole Community Hospitals are located more than 35 miles from other hospitals and designated by the CMS. Sole Community hospitals must also provide a minimum amount of inpatient care to Medicaid and low-income Medicare patients. These hospitals became eligible for 340B participation under the Affordable Care Act of 2010.	Other Hospitals	Hospital
Title X Family Planning Clinic	1	Title X family planning clinics receive federal funding to provide contraceptive services, counseling, and reproductive health-related preventive services, with priority given to low-income people.	Disease-Specific Federal Grantee	Federal Grantee
Tribal / Urban Indian Health Center	1	Tribal Contract or Compact Health Centers are operated by Tribes or Tribal organizations and Urban Indian Health Centers and are outpatient health care programs that specialize in caring for American Indians and Alaska natives.	Safety Net Federal Grantee	Federal Grantee
Tuberculosis Clinic	2	Clinics that receive funding from their state tuberculosis control offices to prevent, diagnose and treat tuberculosis. The Centers for Disease Control and Prevention administers the program.	Disease-Specific Federal Grantee	Federal Grantee

Appendix 3: Data Elements

Covered Entities were required to submit data on acquisition costs, payments received as reimbursements, and operational costs associated with administering their 340B programs. The following outlines the required and calculated data elements used to assess 340B program revenues and costs, as well as payer type classifications.

Required data elements

- **Acquisition costs:** The total dollar amount a Covered Entity paid—directly or indirectly—to purchase 340B drugs from drug manufacturers at 340B discounted prices.
- **Payments received:** The total payments a Covered Entity received—directly or indirectly—from patients and their insurers for 340B drugs that the Covered Entity prescribed to their patients. These are often referred to as reimbursements and primarily used in this report. This includes all payments for 340B drugs, including payments facilitated by contract pharmacies (such as reimbursements, copayments, and coinsurance), cash payments from patients, and any other payment forms.
- **Number of pricing units:** The total amount of pricing units dispensed or administered. Pricing units are the smallest dispensable amount of a prescription drug product that could be dispensed or administered (e.g., gram or milliliter).
- **Contract pharmacy costs:** The total fees and other payments Covered Entities paid to contract pharmacies to distribute 340B drugs. These are often assessed on a per-prescription basis.
- **Other external costs:** The total of any other costs paid to external entities (not the Covered Entity or a child site) that is not a contract pharmacy related to administering a 340B program. This predominately includes fees paid to third-party administrators (TPAs) to perform accounting and distribution functions for Covered Entities.
- **Internal costs:** Total of all internal costs of administering a 340B program. This could include staffing or IT costs.

Calculated data elements

- **Total operational costs:** The sum of payments made to contract pharmacies and other intermediaries for program administration (e.g., fees charged by TPAs), as well as the internal costs to administer a 340B program. It is the sum of *contract pharmacy costs*, *other external costs*, and *internal costs.*
- **Gross 340B revenue:** Funds generated by Covered Entities, which is the value of total *payments received* less *acquisition costs*. Gross 340B revenue does not reflect expenditures incurred by the Covered Entity to operate the program.
- **Estimated missing reimbursements:** An estimate, based on information provided by Covered Entities, of reimbursements (the *payments received* data element) for 340B drugs that were not captured in data extractions due to the bundling of claims.
- **Net 340B revenue:** Net 340B revenue equals *gross 340B revenue* minus *total operational costs*. It is total *payments received* minus the sum of *acquisition costs*, *contract pharmacy costs*, *other external costs* (e.g., TPA fees), and *internal costs* (e.g., staffing). Net 340B revenue indicates the full financial impact to a Covered Entity of participating in the 340B program. Other names for net 340B revenue

used across industry, government, and research include “340B savings,” “340B spread,” and “340B profits.”

Payer types

Covered Entities were required to submit data on the number of pricing units and total payments received by payer type. Payers are the parties responsible for reimbursing Covered Entities for the care or drugs provided.

- **Commercial:** This refers to any private health insurance carrier.
- **Medicare:** This is a federal health insurance program for people aged 65 or older and certain younger people with disabilities.
- **Minnesota Health Care Programs (MHCP)**: This payer type includes Medical Assistance (Medicaid) and MinnesotaCare.[32] These programs serve low-income children and parents, older adults, people with disabilities, adults without children, and people who are income-eligible and unable to access affordable employer-sponsored health insurance.
- **Other:** This includes all other payment types, including a combination of special payment programs and cash payments from uninsured and insured patients (self-pay).

[32] Medical Assistance and MinnesotaCare were separated in data collection but are grouped for this report.

Appendix 4: Data limitations and notes

MDH reviewed all submissions and evaluated each for both quality and completeness, including whether the submission included both administered and dispensed drugs. Nearly all reports required general follow-up for clarifications, and a small number of Covered Entities required targeted engagement to validate their submissions. This section summarizes major themes and areas of particular quality concerns:

1. **Reporting of pricing units**
   MDH was unable to report on the volume of 340B drugs administered or dispensed in 2024 due to *significant* inconsistency in reporting pricing units. Covered Entities were required to report on the number of 340B *pricing units administered or dispensed*,[33] allowing MDH to aggregate the total number of pricing units dispensed statewide, make volume-based comparisons across Covered Entity groupings, and calculate the average net 340B revenue per pricing unit. Approximately half of the Covered Entities reported using pricing units while the other half reported using claims or prescription fills. Additionally, some Covered Entities used different units within the same submission. As there is not a reliable method for reconciling pricing units and prescription fills, this inconsistency and mix of unit reporting rendered volumetric data unusable.

2. **Reimbursements for administered drugs**

   Missing reimbursement data for administered drugs: Covered Entities were required to submit 2024 data on both dispensed and administered drugs to capture the full scope of 340B program size and associated costs in Minnesota. Reporting on administered drugs proved challenging for many Covered Entities, and it is likely that some 2024 data are missing due to incomplete reporting, leading to a possible undercount of metrics such as net 340B revenue.

   Based on MDH guidance to address the challenges of reporting reimbursements for administered drugs, some Covered Entities that could not obtain the actual reimbursement amount were instructed to additionally provide an estimate of the amount of reimbursement that was missing. Not all Covered Entities provided this. To capture the known missing reimbursements, MDH calculated the submitted estimates of missing reimbursement and added them to reported reimbursements to obtain an adjusted reimbursement figure. This adjusted reimbursement figure was used as an input in calculating the overall net 340B revenue but still does not include the unknown missing reimbursements.

   Missing data on scope of drug reporting: Few Covered Entities followed MDH guidance to provide information on the scope of drugs included in each submission. To ensure complete reporting, MDH asked Covered Entities to clarify the scope of their reporting in a post-submission survey. Survey responses were sometimes unclear or conflicted with previously stated information, and some surveys were never completed. In total, approximately 12% of Covered Entities reported only on dispensed

[33] "Pricing Unit" means the smallest dispensable amount of a prescription drug product that can be dispensed or administered (e.g., gram or milliliter). Form and Manner for 340B Covered Entity Reporting, 2026 (https://www.health.state.mn.us/data/340b/docs/fm2026.pdf)

drugs and omitted administered drugs, approximately 82% reported on the full scope of their administered and dispensed 340B drugs; MDH could not determine the scope of reporting for approximately 7% of Covered Entities. Once weighted for total acquisition costs, Covered Entities whose reports included the full scope of their 340B drugs—including administered drugs, if applicable—accounted for approximately 97% of reported acquisition data. The uncertainty of which drugs were included in submissions suggests that a relatively small but unknown percentage of administered drug data is missing.

Varied methods for calculating reimbursements for administered drugs: Inconsistencies and unverifiable methods in reporting administered drug data meant that reimbursement data were likely inaccurate. Due to stakeholder feedback about the challenges of extracting and reporting data on reimbursements received for administered drugs, MDH developed guidance for Covered Entities on how to report these data in the most complete manner.[34]

Covered Entities' submissions—such as comments and methods submitted by some entities—and post-submission surveys showed multiple reasons for uncertainty surrounding reimbursement data for administered drugs:[35]

- More than half of all Covered Entities reported using estimates rather than actuals for administered drugs.
- Despite MDH guidance, many entities did not identify their estimation method.
- Submissions that did include information about the estimation method indicated inconsistencies within submissions and the estimation methods used across Covered Entities varied significantly.
- MDH was not able to validate the methods, nor the input data used in the development of most of these estimates.

All these factors indicate the reimbursement data are likely inaccurate—although MDH is unable to determine the magnitude nor the directionality of a potential miscount. Any such inaccuracy would affect all net and gross 340B revenue calculations and analyses that use revenue data.

3. **Reporting of internal costs**

Internal costs—one of three types of required operational costs data fields that account for the total amount needed to operate 340B programs—serves to capture operational expenditures incurred by the Covered Entity *directly* related to administering a 340B program.[36] Internal costs could be staffing, training, or internal administrative costs.

Reporting on internal costs was inconsistent. While there is no way to validate these costs, MDH observed that several Covered Entities reported substantial internal costs (sometimes greater than 90%

[34] Reporting Administered 340B Drug Data in 2025 (https://www.health.state.mn.us/data/340b/docs/admindrug2025.pdf)

[35] Covered Entities largely reported using actuals for dispensed drugs and this data appears sound. However, dispensed and administered drug data are aggregated in submissions to MDH.

[36] The other two operational cost fields capture payments made to external entities: contract pharmacies and other external vendors, such as third party administrators.

of total program expenditures including acquisition costs), attributed general operational expenses to 340B program operational expenses (such as including Minnesota Care Tax), and included vague categories like “waste” and “other.” Internal cost data should be used with caution, and these indicators show it is possible internal costs are inflated, resulting in deflated net 340B revenue.

Appendix 5: Policy landscape

The 340B landscape has continued to evolve since Minnesota published its first-in-the-nation report on statewide net 340B revenue last year. Policy discussions have been active at both the federal and state levels. A notable federal development was the so-called Cassidy Report in April 2025, which raised concerns about 340B's expansion and limited transparency.[37] The report highlighted potential reforms, including expanded reporting obligations for Covered Entities and increased oversight of contractual arrangements between Covered Entities and external parties, such as contract pharmacies. In September 2025, the Congressional Budget Office (CBO) released a report on the potential causes for the program's expansion.[38] Immediately following the CBO report, federal legislators reintroduced the 340B ACCESS Act to Congress which aims to increase program oversight and transparency.[39]

In 2025, HRSA announced the 340B Rebate Model Pilot Program. Although originally aiming to launch in 2026, the pilot has been paused as of the time of this report's preparation. The pilot would allow approved drug manufacturers to implement a rebate system—as opposed to the traditional upfront 340B discount—for select 340B drugs also included in the Medicare Drug Price Negotiation Program. The pilot program has garnered mixed reactions from stakeholders: some have advocated for its potential to enhance efficiency, increase oversight, and prevent duplicate discounts, while others have expressed concerns about its negative impact on safety net providers—particularly Federally Qualified Health Centers—such as increased administrative burden and financial risk.

Additionally, some manufacturers have attempted to curtail contractual agreements between Covered Entities and contract pharmacies—often limiting each Covered Entity to a single contract pharmacy agreement. In response, several states have passed or proposed laws to limit these manufacturer restrictions. In 2024, Minnesota enacted its own contract pharmacy protection,[40] which has so far withstood legal challenges.[41]

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[37] U.S. Senate Committee on Health, Education, Labor, and Pensions. (2025, April). Congress must act to bring needed reforms to the 340B drug pricing program: Majority staff report. (https://www.help.senate.gov/imo/media/doc/final_340b_majority_staff_reportpdf1.pdf)

[38] Congressional Budget Office. (2025, September). Growth in the 340B drug pricing program. (https://www.cbo.gov/publication/60661)

[39] U.S. Congress. (2025). H.R. 5256: 340B ACCESS Act (119th Cong.) (https://www.congress.gov/bill/119th-congress/house-bill/5256)

[40] Minnesota Statutes 62J.96 (https://www.revisor.mn.gov/statutes/cite/62J.96)

[41] Pharmaceutical Research and Manufacturers of America v. Ellison, No. 62-CV-24-57446 (Minn. Dist. Ct. Ramsey Cnty. Sept. 13, 2024).

A growing number of states have also adopted recurring transparency reporting similar to Minnesota's, and some have experimented with one-time studies or narrower hospital-focused reporting.[42] Several themes have emerged across these state efforts: reporting has increasingly focused on how net 340B revenues are used—including for charity care or discounts for low-income patients—and on oversight of contract pharmacies, third-party administrators, and other vendors.

These state and federal trends reflect an ongoing bipartisan push for 340B transparency and potential program reform amidst strong opposition from Covered Entities' advocates.

[42] At least twelve states, in addition to Minnesota, have passed transparency legislation or are issuing a report on the 340B Drug Pricing Program. Legislation in other states varies significantly, with differences in timing, data, and other details. Some of the data elements other states collect include: the number of patients that receive drugs acquired through the 340B program that paid no cost, out-of-pocket, or paid based on a sliding-scale fee; the percent of all drugs acquired that were acquired through the 340B program; the difference in price between the acquisition costs under the 340B program and acquisition costs through group purchasing organizations; the names of all non-contract pharmacy vendors the Covered Entity works with for their 340B program and a description of their services; the names of all contract pharmacies the Covered Entity works with and their locations; and reporting on the volume of drugs dispensed at contract pharmacies.

Appendix 6: Covered Entities with the largest volume of 340B revenue

MDH identified 25 Covered Entities that together generated the top 90% of statewide net 340B revenue in Minnesota in 2024. In contrast to 2023 data reporting, all entities listed in Appendix Table 6.1 reported on both dispensed and administered drugs, meaning these data should be considered relatively complete. These net 340B revenue figures are not adjusted to account for the estimated missing administered drug reimbursements by Covered Entities.

Appendix Table 6.1: Top net 340B revenue by Covered Entity, unadjusted

Covered Entity Name	340B Covered Entity Type	City	Net 340B Revenue ($)	% of Statewide Net 340B Revenue
M Health Fairview - University of Minnesota Medical Center	Disproportionate Share Hospital	Minneapolis	334,683,472	26.1%
Abbott Northwestern Hospital	Disproportionate Share Hospital	Minneapolis	153,985,063	12.0%
Hennepin Healthcare	Disproportionate Share Hospital	Minneapolis	99,659,845	7.8%
Essentia Health Duluth	Disproportionate Share Hospital	Duluth	76,920,741	6.0%
United Hospital	Disproportionate Share Hospital	St. Paul	63,398,615	5.0%
CentraCare - St. Cloud Hospital	Disproportionate Share Hospital	St. Cloud	52,235,397	4.1%
North Memorial Health	Disproportionate Share Hospital	Robbinsdale	49,955,943	3.9%
Regions Hospital	Disproportionate Share Hospital	St. Paul	47,883,168	3.7%

Covered Entity Name	340B Covered Entity Type	City	Net 340B Revenue ($)	% of Statewide Net 340B Revenue
Mercy Hospital	Disproportionate Share Hospital	Coon Rapids	46,090,233	3.6%
Essentia Health - St. Joseph's Medical Center	Sole Community Hospital	Brainerd	25,242,064	2.0%
New Ulm Medical Center	Critical Access Hospital	New Ulm	22,683,681	1.8%
Sanford Bemidji Medical Center	Disproportionate Share Hospital	Bemidji	19,103,068	1.5%
Cambridge Medical Center	Disproportionate Share Hospital	Cambridge	17,034,720	1.3%
Essentia Health Virginia	Disproportionate Share Hospital	Virginia	16,253,994	1.3%
Grand Itasca Clinic and Hospital	Sole Community Hospital	Grand Rapids	16,237,511	1.3%
Gillette Children's Specialty Healthcare	Children's Hospital	St. Paul	15,000,119	1.2%
M Health Fairview - Center for Blood and Clotting Disorders	CHD Treatment Center	Minneapolis	12,863,206	1.0%
Range Regional Health Services	Disproportionate Share Hospital	Hibbing	12,596,018	1.0%
M Health Fairview - St. John's Hospital	Disproportionate Share Hospital	Maplewood	10,770,611	0.8%

Covered Entity Name	340B Covered Entity Type	City	Net 340B Revenue ($)	% of Statewide Net 340B Revenue
Faribault Medical Center	Disproportionate Share Hospital	Faribault	10,697,207	0.8%
Cuyuna Regional Medical Center	Critical Access Hospital	Crosby	9,126,893	0.7%
St. Luke's Hospital of Duluth	Disproportionate Share Hospital	Duluth	9,107,003	0.7%
Mayo Clinic Health System in Albert Lea	Sole Community Hospital	Albert Lea	8,948,445	0.7%
CCM Health	Critical Access Hospital	Montevideo	7,855,856	0.6%
Children's Minnesota	Children's Hospital	Minneapolis	7,040,712	0.6%
CentraCare - Rice Memorial Hospital	Disproportionate Share Hospital	Willmar	7,029,723	0.5%

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

Appendix Table 6.2 displays the total net 340B revenue for the Covered Entities presented in Appendix Table 6.1 (above) as well as the remaining 156 Covered Entities included in analysis, both with the net 340B amount unadjusted and adjusted for the estimated missing reimbursements for administered drugs.

Appendix Table 6.2: Top net 340B revenue, unadjusted and adjusted

Dimension	Net 340B Revenue ($)	% of Total
Top 25, unadjusted	1,152,403,307	90.3%
Remaining 156, unadjusted	123,840,474	9.7%
Total, unadjusted	**1,276,243,781**	**100%**

Dimension	Net 340B Revenue ($)	% of Total
Top 25, adjusted	1,199,240,413	89.5%
Remaining 156, adjusted	141,030,552	10.5%
Total, adjusted	**1,340,270,964**	**100%**

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

Appendix 7: Drug-level analysis

As in the first report, reporting on 2024 data includes drug-level (NDC) data from hospitals on their top 50 dispensed and administered 340B drugs by volume (see *Drug-level findings* on page 27 for an introduction to this analysis).

By acquisition cost

MDH found that Minnesota mirrors national 340B patterns in terms of acquisition costs and the concentration of a relatively small number of high-cost drugs. In general, high acquisition cost drugs have the potential to drive the largest per-unit 340B revenues as reimbursements remain high and the 340B discount is a large dollar amount. Minnesota payers—patients, health insurers, and the state—bear the cost for this spread in pricing.

National data published by HRSA on the top 10 drugs in terms of national 340B acquisition costs (Covered Entity spending on 340B drug purchases) for 2024 shows spending on these 10 drugs represented approximately one-third of all drug spending for the 340B program.[43] Most of these drugs are high-cost pharmaceuticals purchased through specialty distribution channels—or "specialty drugs." Specialty drugs represent a growing share of total 340B acquisition costs. HRSA noted that although they represented only 40% of total 340B acquisitions *by volume* they accounted for over 60% ($50 billion of $81 billion) of 340B *acquisition costs* in 2024.

In Minnesota, it appears that specialty drugs are also a significant driver of total 340B acquisition costs. In 2024, three of the drugs[44] that appeared on HRSA's "Top 10" list were also within the top 10 drugs by acquisition cost in Minnesota. These three drugs account for nearly 10% of 2024 statewide 340B acquisition costs.

- Trikafta (elexacaftor-tezacaftor-ivacaftor), a cystic fibrosis drug, ranks sixth on HRSA's list and first on Minnesota's list of greatest acquisition costs.
- Keytruda (pembrolizumab), a biologic drug and administered cancer treatment, ranks first on HRSA's list and second on Minnesota's list.
- Biktarvy (bictegravir-emtricitabine-tenofovir alafenamide fumarate), an anti-viral drug, ranks second on HRSA's list and third on Minnesota's list.

It is unclear why some drugs on the HRSA "Top 10" list do not appear as top 340B drugs by acquisition cost in Minnesota. Regardless, this overlap establishes similarities between the 340B program nationally and in Minnesota, particularly regarding the prominent role of specialty drugs.

[43] 2024 340B Covered Entity Purchases (https://www.hrsa.gov/opa/updates/2024-340b-covered-entity-purchases).

[44] Drug is defined here as all drug products within the same drug family (see Appendix 1) that are produced by a single manufacturer.

By gross 340B revenue

Analyzing the top drugs by gross 340B revenue from hospital-reported "top 50" drug data (Appendix Table 7.1), MDH found that hospitals reported on over 1,100 unique drugs. Collectively, these drugs accounted for nearly $185 million in gross 340B revenue.[45] Notably, 20 drugs accounted for 80% ($146 million) of this gross revenue and approximately 10% of reported *statewide* gross 340B revenue. Of these top 20 drugs, 13 are sometimes or always administered by a health care professional—an indicator of the outsized influence of administered drugs on generating 340B revenue.

Some of the top 20 drugs showed considerable growth in gross revenue from 2023 to 2024; it is unclear whether this growth was due to the increased inclusion of administered drugs in 2024, an increase in the provision of these drugs, an increase in the per unit gross revenue, a change in which drugs cleared the "top 50" threshold in 2024 versus 2023, or some combination. Regardless, Humira (adalimumab, a drug that is sometimes administered) generated over $13 million in gross 340B revenue in 2023, but over $26 million in 2024. Trikafta (elexacaftor-tezacaftor-ivacaftor, a dispensed drug) generated approximately $18 million in gross 340B revenue in 2023, but over $26 million in 2024. Together, these two drugs alone accounted for approximately 3.5% of statewide gross 340B revenue.

The concentration of 340B revenue among a small group of high-cost drugs indicates a relatively small portion of hospital prescribing drives a significant share of 340B revenues.

[45] As these data only capture the top 50 drugs for each 340B hospital, a drug in one hospital may be marginally less prescribed by another hospital and could therefore be below the threshold of "top 50;" as a result, these data are not a complete accounting of revenues for each 340B drug statewide.

Appendix Table 7.1: Top 20 drugs by gross 340B revenue, 2024

Drug Name	Brand Name	Manufacturer Name	Primary Indication	Office Administered	Biologic or Biosimilar	Gross 340B Revenue	% of Statewide Gross 340B Revenue
Elexacaftor-Tezacaftor-Ivacaftor	Trikafta	Vertex Pharmaceuticals, Inc.	Cystic fibrosis	No	No	$ 26,483,971	1.76%
Adalimumab	Humira	Abbvie	Autoimmune disorders	Sometimes	Yes	$26,228,277	1.74%
Pembrolizumab	Keytruda	Merck Sharp & Dohme	Cancer	Yes	Yes	$20,014,325	1.35%
Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate	Biktarvy	Gilead Sciences	HIV	No	No	$15,683,091	1.04%
Apixaban	Eliquis	B-M Squibb U.S.	Blood clots	No	No	$9,461,393	0.63%
Propofol	Diprivan	Fresenius Kabi Usa	Anesthesia	Yes	No	$7,508,506	0.50%

Drug Name	Brand Name	Manufacturer Name	Primary Indication	Office Administered	Biologic or Biosimilar	Gross 340B Revenue	% of Statewide Gross 340B Revenue
Semaglutide	Ozempic	Novo Nordisk	Diabetes	No	No	$6,222,635	0.41%
OnabotulinumtoxinA	Botox	Allergan	Muscle spasticity	Yes	Yes	$4,629,817	0.31%
Infliximab-dyyb	Inflectra	Pfizer U.S.	Autoimmune disorders	Yes	Yes	$4,240,016	0.28%
Iohexol	Omnipque	Ge Healthcare	Imaging contrast	Yes	No	$3,946,202	0.26%
Empagliflozin	Jardiance	Boehringer Ingelheim	Diabetes	No	No	$3,817,455	0.25%
Dupilumab	Dupixent	Sanofi Pharmaceuticals	Eczema	Sometimes	Yes	$3,816,558	0.25%
Pegfilgrastim	Neulasta Onpro	Amgen	Neutropenia	Sometimes	Yes	$3,692,158	0.25%
Nivolumab	Opdivo	B-M Squibb U.S.	Cancer	Yes	Yes	$2,599,247	0.22%
Immune Globulin (Human) IV or Subcutaneous	Gammagard	Baxalta	Immune deficiency	Sometimes	Yes	$1,480,752	0.11%

Drug Name	Brand Name	Manufacturer Name	Primary Indication	Office Administered	Biologic or Biosimilar	Gross 340B Revenue	% of Statewide Gross 340B Revenue
Vedolizumab	Entyvio	Takeda Pharmaceuticals	Crohn's & colitis	Sometimes	Yes	$1,469,410	0.10%
Semaglutide (Weight Management)	Wegovy	Novo Nordisk	Weight loss	No	No	$1,368,339	0.10%
Rivaroxaban	Xarelto	Janssen	Blood clots	No	No	$1,368,101	0.10%
Ketorolac Tromethamine	No brand name - Generic	Fresenius Kabi Usa	Pain	Sometimes	No	$1,322,573	0.09%
Midazolam HCl	No brand name - Generic	Hospira	Sedation	Yes	No	$1,125,640	0.09%
Top 20, 2024: Total						$146,478,466	9.84%

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

Minnesota Department of Health

Health Economics Program
St. Paul, MN 55164-0975
health.rx@state.mn.us
www.health.state.mn.us/healtheconomics

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