LOWERING COSTS BY REDUCING THE PRICE OF PRESCRIPTION DRUGS

PENNY PRICE PHARMACY MODEL: LOWER DRUG PRICES WITHOUT NEW TAXES AFTER H.R. 1

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May 2026

New Yorkers are burdened by high healthcare costs.

Most New Yorkers struggle to afford healthcare. Two in three state residents reported that they delayed or went without care because of cost in 2024.[1] By 2025, employer-sponsored family coverage exceeded $35,000 annually, and it continues to rise much faster than inflation.[2] Employer contributions are projected to increase another 10 percent—to more than $17,000 per employee—this year alone.[3] All told, New York State has the highest single coverage cost and fifth-highest family coverage cost in the nation.[4]

Although New York City residents and employers are paying more for healthcare than ever, providers—including hospitals, physician practices, and pharmacies—are closing in droves, citing financial distress and stranding patients in care deserts. For instance, between January and August 2024, at least 29 independent pharmacies in New York City closed due to declining reimbursement rates.[5] Meanwhile, there are 53 population health professional shortage areas in New York City: 23 for primary care, 17 for mental healthcare, and 13 for dental care.[6]

President Donald Trump and Republicans' health policies have exacerbated these affordability and access concerns. As a result of H.R. 1—which ended premium subsidies for Affordable Care Act (ACA) plans, cut Medicaid funding, and imposed new Medicaid work requirements—the typical family enrolled in an ACA plan is expected to pay $3,735 more in annual premiums.[7] For the same reason, upwards of 1.5 million New York state residents may lose their health insurance and 13 New York City safety-net hospitals are at risk of closing, reducing services, or laying off workers.[8]

NYC can provide affordable prescription drugs to newly uninsured New Yorkers at no cost to taxpayers.

The Mamdani Administration should work with NYC Health and Hospitals (H+H) to extend to more un- and underinsured New Yorkers the discounted price H+H pays to acquire outpatient drugs under the federal 340B Drug Pricing Program—as low as $0.03 for insulin and $15 for injectable epinephrine[9]—plus a modest fee to cover overhead.[10]

The 340B program requires manufacturers that participate in Medicaid to sell outpatient drugs to federally qualified health centers (FQHCs)—of which H+H owns and operates 29—and other safety-net providers at a significant discount, typically around 50 percent.[11] Often, the discounted price falls as low as $0.01, in what is known as "penny pricing."[12] For instance, program participants have been able to purchase Humira—the top-selling drug in the world, with an annual list price of $90,000—for $0.01 since 2016.[13]

H+H should adopt a "penny price pharmacy" model, under which it would charge certain established patients of its FQHCs low cash prices for eligible outpatient drugs.[14] Nearly all self- and physician-administered drugs dispensed in the outpatient setting whose manufacturers participate in Medicaid are eligible for 340B discounts.[15] Notable exceptions include vaccines and orphan drugs, used to treat rare diseases.[16] These low cash prices would be available to patients who are uninsured or enrolled in employer- or exchange-based health plans, many of which have high deductibles. They would not be available to established patients enrolled in Medicaid, whose out-of-pocket drug costs are very low, or Medicare, whose annual out-of-pocket drug costs are capped at $2,100.[17]

FQHCs already pass along a lot of their 340B savings to patients because they are required to have a sliding fee scale based on income.[18] However, to maximize impact, H+H should launch an aggressive outreach campaign, including by setting up an official process for un- and underinsured residents—especially those who lose coverage as a result of H.R. 1—to become established patients so that they could benefit.[19] The number of newly established H+H patients relative to the number of un- and underinsured New Yorkers would be a good metric of success for this program, which would be life-changing for residents—such as those with chronic illness—who require affordable and reliable access to drugs to survive.

Because H+H would simply extend its discount to residents who would otherwise fall through the social safety net, this model is free for the City to implement and does not require any legislative or regulatory reform. H+H could set the dispensing fee to account for any overhead costs associated with seeing more patients.

This pricing structure mirrors the New York State Medicaid Pharmacy (NYRx) program, which reimburses pharmacies for acquisition cost, plus a $10.18 dispensing fee.[20]

The City could also expand use of the penny price pharmacy model beyond the H+H umbrella to all 340B participating providers, including nonprofit hospitals. This would be a bigger lift because many nonprofit hospitals do not pass through 340B discounts to patients, instead diverting them to their own bottom lines.[21] According to one study, participating hospitals charge patients with commercial insurance, on average, five times more to dispense drugs than they pay manufacturers to acquire them.[22] In other words, net 340B revenue often subsidizes hospitals rather than the low-income patients for whom they are meant to care.

Specifically, the City could develop new guidelines for all 340B participant providers that recommend they adopt the penny price pharmacy model. It could further encourage hospitals to adhere to this guidance by providing a one-time payment to offset the administrative costs of making changes to dispensing practices and pharmacy budgets.

Although federal statute requires that 340B discounted prices be kept secret, a 2024 report by the Minnesota Department of Health provides a glimpse at the possible patient savings.[23] The report found that in-state program participants generated, on average, $3,405 in net 340B revenue per prescription of Humira—which they purchased for $0.01—and $569 per prescription of Ozempic, a brand-name anti-diabetic, in 2023.[24] This means that patients who are un- or underinsured could save hundreds to thousands of dollars per prescription under the penny price pharmacy model.

Importantly, the penny price pharmacy model would not harm independent pharmacies, which are increasingly at risk of closure.[25] Under the 340B program, some participating providers contract with outside pharmacies to dispense drugs on their behalf, typically reimbursing them a flat fee.[26] Large retail pharmacy chains as well as mail-order and specialty pharmacies that are vertically integrated with insurance conglomerates have more leverage than independent pharmacies in reimbursement negotiations with participating providers.[27] As a result, independent pharmacies often break even or lose money on brand-name 340B prescriptions, while their larger competitors reap excess profits.[28] For this reason, independent pharmacies may prefer that participating providers handle such prescriptions in house.

Conclusion

The penny price pharmacy model is not a panacea. It does not address the two main drivers of high prescription drug costs in the United States: monopolistic brand-name drug manufacturers and pharmacy benefit managers (PBMs).[29] It also does not address rising healthcare costs for non-drug services. Pending structural federal legislative reform, however, it gives the City a lever to pull to make outpatient prescription drugs affordable for all New Yorkers, regardless of income level or coverage status, at no additional cost to taxpayers. It also reinforces the social safety net to withstand additional pressure in the wake of H.R. 1.

Endnotes

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