How the 340B Drug Pricing Program Helps Ryan White Clinics Care for HIV Patients

Plus: Four reasons why the rebate model pilot proposed by federal agency HRSA will move 340B backward and lead to higher drug prices.

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For most of my career, I have stood on the front lines of the HIV epidemic. It is difficult to watch people position themselves as friends of the HIV community while using their platforms to push misinformation about 340B, one of the few policy tools that reliably strengthens the nation's health care safety net.

Let me explain, clearly and factually, how 340B enables Ryan White clinics to deliver high-quality care, and why Ryan White Clinics for 340B Access (RWC-340B) strongly opposes HRSA's new 340B rebate model pilot. (HRSA is the Health Resources and Services Administration, an agency within the Department of Health and Human Services whose HIV/AIDS Bureau oversees the Ryan White HIV/AIDS Program, which provices HIV services, including treatment and prevention, to slightly more than half of all people diagnosed wih HIV in the United State.)

Congress enacted the 340B Drug Pricing Program in 1992 to allow safety-net providers—clinics and hospitals that treat low-income, uninsured and underinsured patients in underserved and rural communities—to stretch scarce resources by purchasing medications at discounted prices. The savings are reinvested into patient care. Not only do these savings sustain access to medication, but also enable clinics to fund primary care, pharmacy services, mental health support, case management and more.

One of the most effective features of the 340B program is that it works at no cost to taxpayers. No federal government dollars are involved. No insurance games or loopholes. Just straightforward savings that help safety-net health care providers care for vulnerable patients. Drug companies volunteer to participate in the 340B discount program in exchange for having their drugs covered by Medicaid and Medicare Part B—the largest commercial opportunity on the planet.

Alarmingly, HRSA just rolled out a 340B rebate model pilot under which participating clinics and hospitals will have to pay full price for nine different drugs up front, then submit paperwork to receive rebates from the drug manufacturers later—no longer an upfront discount. This gives

manufacturers sole authority to determine whether a covered entity qualifies for a 340B discount.

This will have destructive impact on the Ryan White HIV/AIDS Program, which is the largest federal initiative dedicated to providing comprehensive care, medication and support services for low-income individuals living with HIV. It is also one of the most effective care systems ever built, evidenced by outcomes that far exceed national averages. Ryan White Clinics achieve viral load suppression rates approaching or surpassing 90 percent, compared to a national average closer to 66 percent. These outcomes exist because the 340B savings allow clinics to invest in the full continuum of HIV care, and any reduction will undermine the progress we have made in controlling the HIV/AIDS epidemic. If expanded to include other drugs, the damage will only grow worse.

Ryan White Clinics for 340B Access therefore strongly opposes the HRSA rebate model pilot, for the following important reasons:

- Ryan White clinics will incur significant financial, administrative, and labor costs in attempting to secure rebates after the fact, taking time and resources from patient care.

- Reduced 340B savings will force Ryan White clinics to cut primary care, case management, behavioral health, and other support services. New burdens will make contract pharmacies less willing to partner with covered entities and RWCs will have difficulty providing patients with financial assistance at the pharmacy counter.

- Manufacturers will be able to use the rebate model and access to covered entities' claims data to deny 340B discounts. Without proper safeguards, the rebate program risks inappropriate expansion and potential misuse of covered entities' data.

- When covered entities carve out Medicaid claims from 340B due to the increased burdens of the rebate model, state Medicaid programs will face higher drug costs.

The combined effects of the rebate model could force some Ryan White clinics, particularly in rural or underserved areas, to close. This reduces care capacity and undermines efforts to link patients to treatment, manage care, and combat the HIV/AIDS epidemic.

The facts are clear: drug companies are the ones setting sky-high prices, not safety-net providers or community clinics. Global prescription drug sales totaled more than $1 billion in 2024. Total net spending on prescription drugs climbed 11.4% in 2024—while prescription drug use grew by just

1.7%. These prices have risen far faster than inflation, wages, or overall health care spending.

Nonetheless, the drug companies are engaged in a campaign to discredit 340B. PhRMA, their main trade association, has spent tens of millions of dollars to enlist think tanks, lobbying groups, and even “patient advocacy” organizations that are actually funded by the drug companies themselves.

Federal courts have repeatedly ruled in favor of safety net providers and rejected the industry’s attempts to rewrite the rules. In Congress, as recently as October 23, 2025, at a hearing of the U.S. Senate Committee on Health, Education, Labor and Pensions, expert witnesses testified that 340B provides critical savings to safety-net providers, enabling them to care for high-risk patients – and Senators voiced their strong, loud and bipartisan support, Republicans and Democrats alike.

We should listen to the sentiment from both sides of the aisle in that hearing: 340B works and must be protected. Unfortunately, HRSA’s rebate model pilot moves the 340B program toward undue risk and devastating impact.

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