TuSalud

Why the 340B Rebate Model Puts Patients Before Profits

The ADAP Advocacy CEO and the ADAP Advocacy 340B Patient Advisory Committee Chair make an urgent case for reform.

November 5, 2025 By Brandon Macsata and Guy Anthony

The State AIDS Drug Assistance Programs (ADAPs), authorized under the Ryan White CARE Act in 1996, serve as the payor of last resort for people living with HIV/AIDS who otherwise cannot afford their life- saving medications. Since 1996, ADAPs have saved literally millions of lives. Only four years earlier, in 1992, Congress created the 340B Drug Pricing Program "to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." 340B has saved millions of lives, too. But that program, unfortunately, has lost its way. With a growing chorus calling for long-overdue reforms to the 340B Program, State AIDS Drug Assistance Programs, which use the rebate model, offer a way to bring the 340B Program back to its original intent.

The initial concept for the 340B Program was simple and powerful. Pharmaceutical manufacturers provide steeply discounted drugs to hospitals, healthcare providers, and clinics that serve uninsured and underinsured patients—often located in the most vulnerable and underserved communities. For patients living with HIV, it provided Ryan White Clinics and hemophilia treatment centers with critically essential resources to address the HIV/AIDS crisis from the 1990s up until the present day. Today, patients living with HIV can successfully access highly effective therapies to manage the disease and achieve undetectable status, thus making a robust 340B Program essential. Unfortunately, that concept has warped into putting hospital profits before patients.

How so?

In 1992, the 340B program included 1,000 covered entities along with their registered sites. Currently, there are over 53,000 sites, including more than 40 percent of all hospitals nationwide.[1] Since 2010, the number of 340B contract pharmacies has increased by over 2,400%. Now, more than half of U.S. pharmacies—over 33,000 locations—dispense 340B drugs.[2]

But the number of entities involved in the program is not the only measure of its explosive growth. The program's sales at list price—a measure of reimbursement value—grew to $124B in 2023.[3] With the value of discounted purchases under the 340B Program reaching $66.3 billion in 2023,

the 340B “spread” between low acquisition prices and higher reimbursements from health care payers was $58 billion. The program in 2023 was ten times its size in 2010.[4] At this point, prescription drug expenditures under 340B exceed those in Medicaid, with hospitals driving that growth and receiving more than 80% of the program’s benefits.[5]

Why is this important?

The program’s explosive growth should translate into more affordable medical care in the U.S., but the exact opposite is true. Against the backdrop of this program’s explosive growth, patient medical debt has reached a crisis proportion. Medical debt is a crippling financial burden for many Americans, with most of it owed to hospitals. Approximately 100 million adults have medical debt ranging from $500 to over $5,000.[6] Despite changes credit reporting agencies made in 2022, 15 million Americans still have more than $49 billion in unpaid medical collections on their credit reports.[7] Medical debt is a terrible financial burden and drives poor healthcare outcomes linked to the denial of care. Although medical debt relief efforts continue to move forward at the federal and state levels, patients in need continue to suffer. With 340B hospitals accounting for just 2.15% of their expenditures on charity care, the explosive growth of the 340B program is not contributing as much as it should to the affordability of drug therapies and other health care services. 340B hospital profits from 340B drugs are booming, but charity care assistance is falling.

Until 340B reform efforts bring greater accountability and transparency to the program, hospitals will continue to be driven by their economic self-interest at the expense of patients in need and patient access. That accountability and transparency can best be achieved by replacing the current “blank check” of up-front 340B discounts with prompt payments under a rebate payment system, the usual way that pricing concessions are provided in the marketplace. This rebate mechanism will require that requests for 340B pricing be accompanied by data demonstrating that 340B drugs are being used appropriately for 340B patients.

This kind of rebate mechanism should permit patients to see—for the first time—whether they are getting the benefit of lower 340B prices when they pay out of pocket at the pharmacy counter. Sadly, 95% of patients at 340B contract pharmacies receive no demonstrable assistance with their out-of-pocket costs at the pharmacy counter.

For 27 years, ADAPs have operated through a rebate mechanism, providing the gold standard for broader implementation of that well-established system. State Drug Assistance Programs demonstrate how rebates can—and should—operate in the best interests of all 340B stakeholders. Using a rebate model, ADAPs have been able to dramatically grow their drug and non-drug services for patients living with HIV/AIDS, while providing financial assistance to patients and funding for non-drug HIV/AIDS support services. Significantly, 340B-related ADAP drug rebates accounted for just 5% of ADAP funding for patients in 1997, the year before the rebate system began. By 2022, those rebates successfully and efficiently funded 47% of programs, an increase of more than 800%, including substantial direct financial assistance to drug patients in need.[8] 340B rebates used by ADAPs, which are now estimated to fund nearly 55% of these programs in 2025,

are both effective and proven.[9] Rebates, as the ADAP experience shows, bring accountability and ensure that patients are benefiting from the program.

Much larger, better-resourced 340B hospitals are in an even better position to operate effectively under a rebate model than the pharmacies that participate in ADAPs. ADAPs are predicated on annual, means- based, federal funding awards to each state program. They are significantly smaller than the vast majority of 340B hospitals, which often have large yearly revenue streams.

The kind of accountability we support is reflected in the 340B ACCESS Act (Affording Care for Communities and Ensuring a Strong Safety-Net Act), introduced by Reps. Buddy Carter (R-GA) and Diana Harshbarger (R-TN). The 340B Access would clearly define WHO qualifies as a 340B patient, ensure patients can afford their drugs, and bring long-overdue transparency to how hospitals use their 340B profits. The goal is simple: to make sure the program puts patients over profits and stays true to its original mission; to stretch limited federal resources as far as possible for those eligible patients who use 340B drugs. As advocates who have both benefited from and fought to protect this program, we see this legislation as more than just the right policy. It's a lifeline for a program under assault by some hospitals that are abusing it and hurting patients.

There is some pushback against the proposed 340B rebate model. That pushback is, for the most part, predicated on the fear of some large hospitals that rebates will result in their losing control over a revenue cash cow that currently comes with essentially no strings attached. Though many 340B covered entities effectively leverage their 340B dollars as intended by the original legislation, to provide benefits to patients in need, too many large hospitals are gaming the system for their own institutional benefit, without ensuring that the program results in meaningful community benefit.

State AIDS Drug Assistance Programs have put patients living with HIV first for nearly 30 years, thanks to the 340B Program. Isn't it time for all patients living with chronic and rare health conditions to see the same benefit from the 340B program? A transparent rebate payment system will do exactly that.

Brandon M. Macsata is CEO of the ADAP Advocacy Association and Guy Anthony is chair of the ADAP Advocacy 340B Patient Advisory Committee.

For a different perspective on 340B from Alan Witchey, president and CEO of the Damien Center, click here.

Footnotes:

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