# Big Pharma Fights the 340B Federal Drug Discount Program, Puts Profits Over Patients

Big Pharma is waging war against a drug discount program that serves rural and underserved communities, writes the Ryan White Clinics.

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Big Pharma is waging an all-out war against a federal drug discount program that serves rural and underserved communities. Profit is the motive. Patients are the victims.

Pharmaceutical manufacturers set sky-high drug prices and reap hundreds of billions of dollars in profits every year. A substantial portion of that money comes from prescriptions covered by Medicare and Medicaid. To access that vast, taxpayer-funded market, drug makers opt-in to the federal 340B Drug Pricing Program and agree to sell certain medications at a discount to safety-net healthcare clinics. The savings fund primary care, mental health services, and wraparound care that make effective treatment possible for the most vulnerable patients in America. 340B funds clinics and makes care possible. 340B is the government's design to fund the safety-net.

As the story goes for the pharmaceutical industry, their already massive profits aren't enough, and 340B discounts are in their crosshairs.

On one front of their war on 340B, drug companies have been unilaterally imposing new policies to reduce or avoid the discounts they are legally required to provide, including restricting access to contract pharmacies, imposing burdensome data requirements on covered entities, eliminating discounts for STI (sexually transmitted infections) clinics, and even redefining who qualifies as a "patient" under the program. Many of these policies have already been challenged in court and found to be unlawful, but that does not stop them.

On the other front, they are spending tens of millions of dollars every month to erode public and political support for 340B and change relevant laws and regulations, with tactics ranging from conventional lobbying and advertising to funding front groups and astroturfing campaigns that mimic grassroots opposition.

# The proposed rebate model is a radical change that hands drugmakers control over who receives discounts and when.

In the first half of 2026 alone, PhRMA and 18 of the largest drug companies spent nearly $100 million on lobbying. On top of that, PhRMA recently launched a seven-figure advertising campaign attacking the 340B program.

Of all the attacks, a recently proposed rebate model is perhaps the most dangerous. Today, safety-net providers receive guaranteed discounts on medications at the point of purchase, so the savings are immediate and certain. Under the rebate model, providers would be required to pay the full, undiscounted price upfront, then wait for drug companies to determine eligibility, issue refunds, and actually send a check.

As nonprofits, Ryan White Clinics cannot match Big Pharma's budgets for lobbyists and advertising campaigns. However, when the federal Health Resources & Services Administration (HRSA), which oversees the Ryan White HIV/AIDS Program, issued a Request for Information and an Information Collection Request on the rebate model, the Ryan White Clinics for 340B Access (RWC-340B) and its member organizations submitted formal comments opposing the proposal, documenting in great detail how the agency has dramatically underestimated the burden it would impose on safety-net providers as well as the devastating harm it would inflict on patient care.

Clinics spent weeks laboriously providing impact data to HRSA. Days after the submission deadline, HRSA advanced the rebate model to the White House Office of Management and Budget for review. A thorough review of the comments would have been impossible in that timeframe. However, our subsequent analysis found that — notwithstanding thousands of identical comments, submitted alphabetically, and tied to a patient advocacy group backed by pharmaceutical manufacturers in support of the rebate model — an overwhelming majority of comments were strongly opposed to the proposal, by an 18 to 1 margin.

Under the rebate model, Ryan White Clinics would be required to float interest-free loans to some of the most profitable corporations in the world, paying full price for medications upfront while waiting weeks or months for a rebate. And the pharmaceutical companies themselves would have the power to decide when, or even if, to cut those checks at all.

Such a radical change would hand the drug manufacturers unprecedented power over the safety-net healthcare system. They would assume authority over which medications, which patients, and which clinics qualify for a discount; decisions that have always belonged to doctors, patients, and clinics themselves. The beneficiaries would be drug manufacturers. The casualties would be the safety-net clinics and their patients. Every dollar delayed or denied would be a dollar taken from

patients. Every hour spent filing claims and fighting denials would be an hour taken from patients.

There is a better path forward. Rather than a rebate model that hands manufacturers control over who receives discounts and when, policymakers should work with the Centers for Medicare and Medicaid Services to establish a neutral federal clearinghouse, an efficient, conflict-free system that prevents duplicate discounts before they occur without putting the drug industry in charge of a program it has spent years trying to dismantle.

The battle lines are drawn: on one side, drug manufacturers fighting to inflate their profits; on the other, safety-net clinics struggling to stretch scarce resources to serve vulnerable patients in rural and underserved communities. Policymakers must choose a side.

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