Health Providers Race to Navigate Pharma's New Drug Rebate Plan

Nov 25, 2025, 5:05 AM EST
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Thousands of health providers that treat lower-income and uninsured patients are scrambling to adjust to a new program to access steeply discounted medicines from drugmakers that stands to overhaul their operations and finances.

The 340B Rebate Model Pilot Program, administered by the US Health Resources & Services Administration, is set to significantly change how the 340B Drug Pricing Program operates after the Trump administration approved rebate models from pharmaceutical companies such as Bristol Myers Squibb Co., Johnson & Johnson, and Novo Nordisk A/S.

Drugmakers under the federal program currently provide up-front drug discounts to covered safety-net hospitals, clinics, and health centers that treat a disproportionate number of low-income and uninsured patients. But under the pilot, covered providers, starting on Jan. 1, 2026, will buy certain medicines at full price and then submit data to drugmakers to receive a rebate.

Health providers are now preparing for the pilot—grappling with nine unique drugmaker models, weighing operational changes, and analyzing the financial risks with purchasing drugs at commercial prices.

"A lot of entities are trying to figure out what reports they can build internally and what resources they need," said Madeline Wallack, co-founder of Rx|X Consulting, which provides 340B compliance services. "They're scrambling to figure out if they can adapt or customize for these manufacturers."

The pilot comes as the 340B program faces heightened scrutiny over its massive growth and how savings from discounts are used. Reports from the Congressional Budget Office and others indicate the program has significantly expanded due to the integration of hospitals and off-site clinics and expanded use of off-site pharmacies that dispense 340B drugs.

The US Department of Health and Human Services' HRSA has been working closely with manufacturers in the pilot to ensure their plans are implemented in accordance with the 340B statute and requirements detailed in the pilot's plan, Emily Hillard, an HHS spokesperson, said in an email.

New Operation

Covered entities will work with new technology platform Beacon Channel Management, where they or their third-party administrator will submit data to the manufacturer in order to get a rebate.

Groups and consultants working with providers have been rolling out webinars on how to operate the platform, educating them on what data to submit and how to prevent program risks.

Covered entities, however, still feel uncertain about the plan.

“The real challenge is how it fits operationally—whether it’s feasible, worth the effort, and possible to do correctly at scale,” said Jonathan Horn, founder of TAS340B, a nonprofit that works with covered entities to improve operation transparency. “Those are the questions teams are wrestling with day to day.”

Some hospitals have been seeking to understand slightly different descriptions in the models, raising questions on whether they have the exact data to submit a rebate claim.

“The definitions really matter,” said Maureen Testoni, president and chief executive officer of 340B Health, a nonprofit representing over 1,600 safety-net hospitals. “Until they know what that is, they can’t start the process of really building new software to pull the data that they need to be able to send.”

Providers are worried about the lack of a dispute resolution process, raising skepticism over how issues will get resolved.

HRSA says that if a claim takes longer than 10 days for a rebate to be paid, covered entities and manufacturers should work to resolve the issue. If the agency observes trends toward a manufacturer not paying rebates within that time frame, it can revoke the rebate model approval for that manufacturer.

“It’s almost like we have to sit and wait until Jan. 1, push all of this data through Beacon, and see what’s going to happen,” said Rhodie Smith, a principal consultant of 340B Efficiency.

Analyzing Costs

Health providers with tighter budgets are weighing cash flow issues as they’ll now purchase drugs with higher price tags.

For example, some 340B health centers might currently pay less than $30 for blood thinner Eliquis per a 30-day equivalent supply, but under the pilot, some are expecting to pay as much as $560.

Federally qualified health centers anticipate overall doubling of inventory cost, said Felicity Homsted, CEO of FQHC 340B Compliance.

“The biggest messaging I’m putting up is to make sure that people’s purchases are actually matching the rebates that they’re seeking,” she said.

The Craneware Group, a partner to 340B covered entities, said rebates would force some providers to pay five times higher than their current 340B acquisition costs.

“We’re preparing, as a company, that this thing could grow,” said Lidia Rodriguez-Hupp, chief customer officer at the Craneware Group. “At least the pilot will be able to show where there are things that could succeed and where there are things that would fail.”

‘A Receipt’

Despite concerns from covered entities, Beacon said it’s been working with providers, manufacturers, and third-party administrators to help implement the pilot.

“It’s the idea of having a receipt when you pay for something,” said Katheryne Richardson, chief strategy officer at Beacon. “A rebate model is essential to understanding where a product went and who paid for it. Our job is to make that happen and to make sure it’s transparent.”

The pharmaceutical industry has long pushed for a rebate system, arguing it would ensure discounts are going to eligible patients.

Beacon has been providing educational webinars in the past few months, outlining how to operate the platform.

“This program is operating on an antiquated chargeback model, which does not have sufficient transparency for the manufacturers,” Richardson said. “What we’re doing is bringing in a transparent model that aligns 340B with other government rebate programs, such as Medicaid.”

Still, some covered entities say it’s not about resisting change, but rather working for a shared framework between drugmakers and providers.

“It’s less about opposition and more about uncertainty,” Horn said. “Many organizations are trying to understand how to adapt without duplicating work or introducing compliance risk.