FAQ: 340B Rebate-based Rapid Verification Model

UNDERSTANDING THE 340B REBATE MODEL

Q: Will a rebate model increase costs significantly for hospitals and clinics?

A: No.

A rebate model would not reduce reimbursement or increase acquisition costs for eligible 340B claims. Hospitals and clinics would still receive the full value of the 340B discount for prescriptions that meet program requirements, just after basic verification, consistent with other standard health care payment practices.

Importantly, hospitals and clinics should already collect the limited data elements needed for verification today, so the model would introduce minimal new administrative burdens. And based on an analysis by IQVIA, hospitals and clinics' financing costs would not be expected to increase under this approach.

Q: Will hospitals and clinics face cash flow challenges under a rebate model?

A: No. In most cases, cash flow would remain unchanged or could even improve.

Under the original pilot (vacated by a court order after hospitals sued):

- Manufacturers would have been required to pay rebates within **10 days** of the submission of a valid, verified claim.
- Hospitals and clinics typically have **30 days** to pay wholesalers.
- This means hospitals and clinics would generally receive rebate payments **before** they are required to pay for the inventory.

Q: How is this different from how hospitals and clinics operate today?

A: It would build on existing practices while adding basic verification.

Hospitals and clinics often already dispense medicines, receive reimbursement, then restock inventory and profit from 340B through pocketing the difference between the lower 340B price and the higher reimbursement.

A rebate model would allow this process to continue but would require hospitals and clinics to provide basic claims level data to verify 340B eligibility before receiving the benefit of 340B pricing.

Q: Will this delay or restrict patient access to medicines?

A: No.

Patients would receive their prescriptions exactly as they do today. 340B eligibility is typically determined after dispensing a medicine, and a rebate model would not delay care and would not change how patients get their medicines.

Q: Is a rebate model designed to limit covered entity participation in the 340B program?

A: No.

The goal is to prevent unauthorized double dipping.

Q: Why is verification necessary in the first place?

A: Because today's system allows hospitals and clinics to receive the 340B price upfront, without confirming eligibility, which has led to:

- Documented cases of double dipping in the program
- Diversion of discounted drugs to ineligible patients
- Increased fraud and abuse within the program.

Verification is standard practice in all other parts of the health care system.

Q: Will a Rebate Model threaten rural hospitals?

A: No.

They would get paid within ten days of submitting a rebate claim, and a rebate structure could make it easier to let them claim 340B pricing on a single unit of a medicine instead of having to wait until a larger package of the medicine has been used up and is ready to be replenished.

Q: What problem does a rebate model solve?

A: It is an efficient way to address administrative complexity created by the Inflation Reduction Act.

A rebate-based rapid verification model would allow the private sector to help address new administrative challenges created by the Inflation Reduction Act (IRA)—reducing federal involvement and saving taxpayer dollars. Without added guardrails, unauthorized duplicate IRA/340B discounts are projected to reach $4 billion in 2026 alone.

Q: Does this create new administrative burdens for hospitals and clinics?

A: No.

A rebate model would rely on data that hospitals and clinics should already be collecting for compliance and claims processing and would mirror standard practices used across:

- Medicare
- Medicaid
- Commercial insurance

No new patient visits, prior authorizations, or eligibility determinations would be required at the point of care.

Q: Why act now?

A: Because the status quo is driving unchecked growth and higher costs without evidence of patient benefit.

Without added guardrails, unauthorized duplicate discounts will continue growing, which drives higher costs for patients, employers, and taxpayers, without evidence of improved patient benefit.