340B Rebate Model: Accountability Over Alarmism

What big, tax-exempt hospitals won't tell you.

The Health Resources and Services Administration (HRSA) is considering implementing a 340B rebate model program. Administering 340B pricing as a rebate would be a straightforward, commonsense fix to help bring transparency and accountability to a program increasingly exploited by large, tax-exempt hospitals for profit.

The big hospital lobby has tried to derail this necessary program update using a flawed, biased survey built on outdated assumptions and lacking any real solutions to documented abuse. New data from the CBO and IQVIA directly refute the misleading rhetoric from big hospitals and show that hospital actions are driving up costs for taxpayers.

A rebate model would require hospitals and clinics to submit basic data to ensure compliance with certain key legal requirements before receiving 340B rebates. This will help prevent many unauthorized duplicate discounts.

Here's the truth to the misleading claims the big hospital lobby is trying to make.

MYTH: There is no authority to offer 340B pricing as a rebate.

FACT: A rebate is explicitly mentioned in the 340B statute and at least two federal courts have recognized that it can be a mechanism for manufacturers to offer 340B pricing.

MYTH: Hospitals will have to "float millions" and face financial ruin.

FACT: Hospitals often use a "replenishment model" where they initially purchase a drug at list price and receive the 340B pricing once all the units in a package have been dispensed. A new analysis from IQVIA confirmed that a rebate model that paid covered entities within 15 days of dispensing a drug wouldn't have financially strained providers. In fact, a rebate model could deliver payments even quicker than the replenishment model, meaning hospitals and clinics would, in most cases, be paid before they have to pay their wholesalers.

MYTH: The rebate model will reduce uncompensated care.

FACT: Studies show that the 340B program does not lead to hospitals providing more uncompensated care. In fact, data reveals 340B hospitals often instead are using the program to pad their profits, expand into wealthier areas and boost financial investments.

MYTH: The rebate model threatens rural hospitals.

FACT: A rebate model would not change rural hospital eligibility for the 340B program and would still ensure that hospitals can be reimbursed before most wholesaler invoices are due. Importantly, hospitals are already required under 340B to maintain the kinds of basic records they would likely submit under a rebate model.

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Concerns raised about rural hospitals are a diversion tactic by big city hospitals that are trying to distract from the fact that many of them are currently masquerading as "rural" providers—abusing loopholes in the 340B program and in Medicare to qualify for federal resources meant to support rural communities and cashing in on discounted medicines intended for providers treating underserved patients.

MYTH: The 340B Health survey proves hospitals can't survive under a rebate model.

FACT: The survey is based on worst-case assumptions and self-reported data from only 13% of 340B hospitals. The survey was fielded before HRSA released its initial rebate notice, so the questions ask about a "worst case scenario" that is nothing like what an actual rebate would be. For example, the survey asks hospitals about the impact of delays of one month or more that apply to a broad set of medicines, even though the 2025 rebate program would have applied only to a small number of drugs and would have required rebate claims to be paid within 10 days, before providers had to pay their wholesalers.

MYTH: Rebate models are administratively burdensome.

FACT: Rebates are standard practice for getting manufacturer price concessions on medicines in federal drug programs. It's already used in Medicare, Medicaid, TRICARE and beyond.

As part of standard practice, hospitals should already maintain auditable records and data required for rebate processing.

Any notion that a rebate model would be a burden on hospitals and clinics doesn't align with how these entities already operate.

MYTH: If the entire 340B program moved to a rebate model, the average Disproportionate Share Hospital in the country would be forced to float an estimated $72.2 million to manufacturers annually.

FACT: That calculation is a meaningless number that adds up the total amount of 340B rebates the average hospital would receive over a given year for all medicines. These hospitals would generally not actually be floating this money because a rebate model would require manufacturers to pay rebates before providers had to pay their wholesalers.

The Bottom Line: A rebate model would be a straightforward and efficient way to increase transparency and integrity of the 340B program. HRSA's exploration of a rebate program is a positive first step towards leveraging this solution to efficiently ensure that program rules and requirements are met.

Tell the Administration to implement a 340B rebate program.

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