A 340B Rebate Model Would Undermine Access to Care

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Overview

The 340B Drug Pricing Program was established by Congress to ensure that hospitals serving low-income, rural and medically underserved communities are able to stretch limited federal resources and use their savings to maintain, improve and expand access to care. Since the program's inception in 1992, the Health Resources and Services Administration (HRSA) has implemented the program as an upfront discounted price available to covered entities at the point-of-sale. In August 2025, HRSA first announced its intent to test a rebate model in place of upfront discounts under a pilot program. In December 2025, a federal court enjoined the agency from moving forward with this rebate program. Subsequently, the agency issued a request for information that the agency then used to introduce a revised version of its rebate program in August 2026 with a start date of January 1, 2027. The agency's new rebate program would apply to all 2026 and 2027 initial price applicability year drugs negotiated by Medicare under the Inflation Reduction Reduction. As explained below, this fundamental change upsetting three decades of agency precedent shifts the financial risk to 340B covered entities, introduces significant and unnecessary administrative burden, and undermines the statutory purpose of the 340B program: to expand access to care for patients and communities across the country.

How would a 340B rebate model change current purchasing?

Under the current 340B framework, eligible hospitals and clinics purchase outpatient drugs at discounted 340B prices at the point of sale. Access to an upfront discount provides predictable, enforceable pricing that allows hospitals to:

- Sustain access to programs and services supported by the 340B program for patients and communities.
- Manage cash flow to ensure financial sustainability.
- More accurately forecast pharmacy budgets to ensure continued access to medications.

In contrast, under a rebate model, hospitals and clinics would no longer receive the 340B discount at the time of purchase. Instead, hospitals would be required to:

1. Pay the full list price for outpatient drugs.
2. Submit onerous amounts of pharmacy and medical claims data to manufacturers (or their third-party vendor) after dispensing the drug.
3. Wait for manufacturers to determine whether a rebate is owed, how much will be paid and when payment will occur.
4. Reconcile any rebate denials as well as approvals to ensure an appropriate rebate was received for the claim submitted in the correct amount.

In effect, hospitals would be asked to finance drug purchases upfront while relying on manufacturers to voluntarily return the statutorily-owed discount after the fact.

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Why does a rebate model raise serious concerns?

- **Risk of Care Delays:** An inability to advance drug costs may lead to treatment delays or reduced access, disproportionately harming vulnerable patients.
- **Financial Risk for Safety-net Hospitals:** Requiring hospitals to front the full cost of high-priced drugs would strain cash flow and threaten access to care. Despite suggestions otherwise, the current "replenishment model" used by 340B hospitals to manage their drug inventory is not the same as a rebate model. Under a replenishment model, hospitals would only pay full price once — at the initial creation of the drug inventory. But a rebate model would require hospitals to pay full price for drugs every time drug inventory is replenished.
- **Manufacturer Control Over Statutory Discounts:** A rebate model would give manufacturers control over whether and when hospitals receive mandatory 340B discounts.
- **Increased Administrative Burdens:** Hospitals would face new systems for tracking, reconciling and disputing rebate claims, diverting resources away from patient care.
- **Lack of Adequate Oversight:** To date, HRSA's rebate model proposal lacks strict enforcement mechanisms, adequate guardrails around claims denials, and dispute resolution processes.

What is the AHA's position?

The AHA strongly opposes replacing upfront 340B discounts with any rebate model. Any changes to the 340B program must preserve point-of-sale pricing, ensure predictable access to savings, maintain independent federal oversight, and protect patients and 340B providers. In addition, the AHA opposes any efforts to carve out individual types of 340B covered entities from a rebate model, as this would undermine the partnerships among providers that coordinate delivery of patient care.

The AHA also is committed to ensuring 340B program integrity and transparency. We support the creation of a neutral, third-party clearinghouse model that would strengthen the government's oversight of the 340B program, minimize administrative burdens for all stakeholders, and ensure continued access to upfront 340B discounted pricing while mitigating any unintended consequences for access to care.

Bottom Line

Congress structured the 340B program to provide upfront pricing certainty — not a back-end rebate. We believe that the costs to patients and 340B providers are too high to justify any rebate model and urge Congress to ensure that upfront 340B pricing is maintained.

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