



April 9, 2026

The Honorable Thomas J. Engels  
Administrator  
Health Resources and Services Administration  
U.S. Department of Health and Human Services  
5600 Fishers Lane Rockville, MD 20852

**RE: Request for Information: 340B Rebate Model Pilot Program, HHS Docket No. HRSA-2026-03042**

Dear Administrator Engels,

The Connecticut Hospital Association (CHA) is a not-for-profit membership organization that represents hospitals and health-related organizations. CHA's mission is to advance the health of individuals and communities by leading, representing, and serving hospitals and healthcare providers across the continuum of care that are accountable to the community and committed to advancing health and health equity.

We appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) "Request for Information (RFI): 340B Rebate Model Pilot Program," which seeks feedback on whether HHS's Health Resources and Services Administration (HRSA) should implement a rebate model under the 340B Drug Pricing Program (340B Program) and "how best to operationalize any such rebate framework for stakeholders."

CHA strongly opposes HRSA implementing a rebate model under the 340B Program. We cannot overstate how detrimental a shift in the way the 340B discount is currently administered, even as a test pilot, would be for our hospitals and their communities.

**Preserve the Existing 340B Program**

For more than 30 years, the purpose of the 340B Program has been to help hospitals stretch "scarce federal resources" to support low-income, uninsured, rural, and medically at-risk individuals, as well as support the delivery of whole-person care, improve health equity, and help hospitals invest in their communities.

As covered entities under the 340B Program, eligible Connecticut hospitals achieve these goals by purchasing drugs at discounted prices, which in turn generates savings that hospitals then use to provide free or reduced-cost care for their patients and to fund the delivery of essential health services to vulnerable populations in their communities.

Restructuring the discount framework (even as a pilot model) to shift away from the longstanding, upfront savings model and instead require hospitals to pursue retrospective manufacturer rebates will destabilize the 340B Program. HRSA's RFI does not provide a reason for why a shift in the discount framework is necessary or what a change in the program's administration is intended to achieve. Instead, HRSA appears to introduce a solution to an undefined problem. Given the multitude of potential negative implications, CHA strongly believes HRSA should abandon the concept altogether and not risk weakening a program that has proven successful.

In support of this position, we outline the considerable financial and administrative challenges operationalizing a rebate pilot presents for Connecticut hospitals.

### **Financial Impacts of a Rebate Model**

On top of existing financial pressures, hospitals today face increasing financial strain due to impending federal policy changes that will impact reimbursement and reduce patient access to health insurance coverage, potentially resulting in a substantial rise in uncompensated care. Transitioning any portion of the 340B Program to a rebate model would further compound these challenges by requiring hospitals, in effect, to extend interest-free loans to manufacturers — costs that have not been budgeted for and that many hospitals cannot absorb while awaiting reimbursement. This will result in an exacerbation of the considerable financial strain hospitals are currently operating under and hinder their ability to fund and continue to provide essential services.

Additionally, HRSA has indicated that it is looking to expand the rebate model pilot program to all drugs included in the Inflation Reduction Act's Medicare Drug Price Negotiation Program through 2027, which means hospitals would need to estimate and plan for a cost burden that would include 25 total drugs across 13 drug companies. Hospitals may also be required to pay the wholesale acquisition cost (WAC), or the highest sale price for a drug (*a price rarely even paid in the market, as the WAC price can be as much as or more than 100 times the 340B price for the drug*). CHA urges HRSA to consider the implications of this cost burden, including the fact that hospitals are unlikely to have sufficient cash reserves to absorb these substantial upfront costs for 25 drugs at above-market prices, and the budget constraints that would be required for these purchases would ultimately constrain drug availability and delay patient care. Smaller or rural hospitals are especially less positioned to offset or absorb the financial impacts of this shift, putting the vulnerable patients within their communities at a disadvantage.

Furthermore, a rebate model raises concerns that manufacturers could institute mechanisms that would delay or deny payment to hospitals. HRSA has not clarified whether safeguards would be put in place to prevent manufacturers from denying rebates or imposing limitations on the criteria for doing so, nor whether hospitals would have access to an expedited appeals process to address denied claims or payment delays.

### **Administrative Burdens and Resource Challenges Associated With a Rebate Model**

For decades, hospitals have been able to reliably estimate the internal resources necessary to operate the upfront discount model, and the benefits of participation have far outweighed any administrative burdens.

However, with the addition of a potential rebate model pilot, hospitals will need to pivot to accommodate two fundamentally different models at the same time. The irrefutable burden of having to administer two counterintuitive discount models simultaneously will be enormously resource intensive, as hospitals would need to contemplate implementing new workflows and processes to track claims, hire more staff, submit rebate requests, reconcile payments, refute potential reimbursement denials, and invest in new information technology systems. Again, it must be emphasized that having to account for potentially 25 different drugs across 13 drug companies as part of a rebate mechanism only exacerbates these administrative burdens.

Similarly, administrative burdens resulting from the rebate pilot would not be felt uniformly amongst hospitals, as smaller and rural hospitals would be disproportionately impacted. For all hospitals, there is concern about what trialing a rebate pilot could mean for the future of the 340B Program, and, absent any clearly identified problems with the current upfront discount framework, implementing a rebate pilot is a slippery slope that will perpetuate uncertainty about what will be required to maintain participation in the program.

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Hospitals are essential partners to HRSA in accomplishing the 340B Program's objective. Absent any clearly identified issues with the existing upfront discount model and considering the significant financial and administrative burdens a rebate approach would impose on hospitals, there is no justification for HRSA to move forward with testing ways to operationalize rebates.

Therefore, CHA strongly urges HRSA to abandon consideration of a rebate model pilot, as it will only undermine hospitals' ability to fulfill their mission and restrict the 340B Program's reach.

Sincerely,

A handwritten signature in cursive script that reads "Marielle Daniels".

Marielle E. Daniels  
Director, Regulatory Advocacy

MED:ljs