Illinois Health and Hospital Association

ICAHN
Illinois Critical Access Hospital Network

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Kennedy:

On behalf of the Illinois Health and Hospital Association (IHA), the Illinois Critical Access Hospital Network (ICAHN) and our 340B-participating hospitals, we write to urge you to reject the effort by several large global drug companies to undermine the 340B Drug Pricing Program by imposing a "rebate model," rather than the longstanding "upfront discount" model that the Department of Health and Human Services (HHS) has permitted since the outset of the program. The 340B Program is a vital lifeline for our 340B-participating hospitals, nearly 70% of which are Critical Access Hospitals and Safety Net Hospitals, just like it is for hospitals around the country that serve rural and low-income communities. We respectfully ask that you deny the drug companies' requests to approve their unlawful "rebate models."

We agree with the American Hospital Association's (AHA) position that these proposed "rebate models" are unlawful and that HHS does not have the legal authority to approve them. In recent litigation over these rebate models, the drug companies themselves argued that settled Supreme Court precedent holds that the 340B statute "forbids[ ] the *private* enforcement of 340B program requirements in all forms." That is *exactly* what the drug companies are trying to do with their rebate models, and exactly what the Supreme Court has said they *cannot* do.

We also agree with the AHA that the drug industry has spun a false narrative about 340B Program abuses and the need for the "rebate models" to address them (instead of the statutory audit procedures). As the AHA's data demonstrates, 340B hospitals are meeting program rules and regulations. The drug companies are not. Hospitals have made significant improvements in compliance over the past five years, which likely reflects the work they have done with third-party administrators and other entities to conduct regular and comprehensive internal self-audits of their 340B programs. Meanwhile, drug companies continue to demonstrate a high degree of non-compliance with program rules and regulations.

We will not repeat the AHA's points here. Instead, we write to briefly explain how damaging the "rebate models" will be to Illinois's healthcare safety net and the vulnerable patients it serves. Generally speaking, the financial impact the "rebate models" will have on the Illinois healthcare safety net will be severe. Floating large sums of money to the drug companies without any guarantee of when — or whether — our 340B hospitals will be paid the discounts they are owed by law is not financially sustainable.

340B hospitals also will have to spend substantial sums to comply with each drug company's unique "rebate policy." If the drug companies are permitted to impose *any* form of a "rebate model," each hospital will be forced to bear a range of administrative costs and burdens that will dramatically drain the 340B discount of economic value. Hospitals are already understaffed, underfunded, and often surviving on slim to negative margins. Adding additional administrative layers to an already complex program will require the hiring of additional staff, the implementation of new workflows and technology, and undoubtedly future legal fees when rebates are erroneously denied.

If forced to incur these costs, Illinois' 340B-participating hospitals will necessarily have to divert limited resources away from patient care. This runs directly counter to the purpose of the 340B Program, which is to allow hospitals to stretch scarce Federal resources as far as possible, reaching more patients and providing more comprehensive services.

Illinois' 340B hospitals provided a total of 1.46 million inpatient Medicaid days in 2024, with an average Medicaid utilization rate of 41% and an average disproportionate share percentage of 43.4% across participating disproportionate share hospitals. These hospitals use 340B Program savings to expand healthcare services in historically underserved communities, including post-discharge chronic disease therapy; care connection clinics in rural areas to expand geographic coverage of primary and specialty care; physical, occupation, speech, and aquatic therapy; and transitional intensive intervention services for medically complex patients. 340B hospitals also leverage 340B pricing to support patients, creating programs based on financial need to pass 340B savings on, provide medications free of charge, and subsidize out-of-pocket costs for medication like insulin and infusion therapies. Simply put, there is no sensible reason for HHS to allow pharmaceutical companies to impede access to care. The costs incurred by hardworking Americans outweigh any purported program integrity benefits of the proposed "rebate model".

We appreciate HHS' careful evaluation of its options. But for 340B hospitals providing lifesaving care across Illinois, the options and consequences are clear: if HHS approves these unlawful "rebate models," patient access to care will suffer.

Sincerely,

A.J. Wilhelmi
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