WISCONSIN HOSPITAL ASSOCIATION

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July 2, 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: Following up on WHA's June 25 Board Meeting Discussion with HRSA Administrator Engels

Dear Administrator Engels:

Thank you for attending WHA's Board of Directors Meeting on June 25. We sincerely appreciate your leadership at HRSA on the many issues facing hospitals across the country, and particularly regarding the administration of the 340B prescription drug discount program.

We wanted to follow up regarding some of the items brought forward in the discussion, including federal legislation being discussed on Capitol Hill, duplicate discounts for drug manufacturers, concerns related manufacturers' motives for 340B rebates rather than up-front discounts, and the overall burden hospitals face in complying with the 340B prescription drug discount program.

1. Federal Legislation

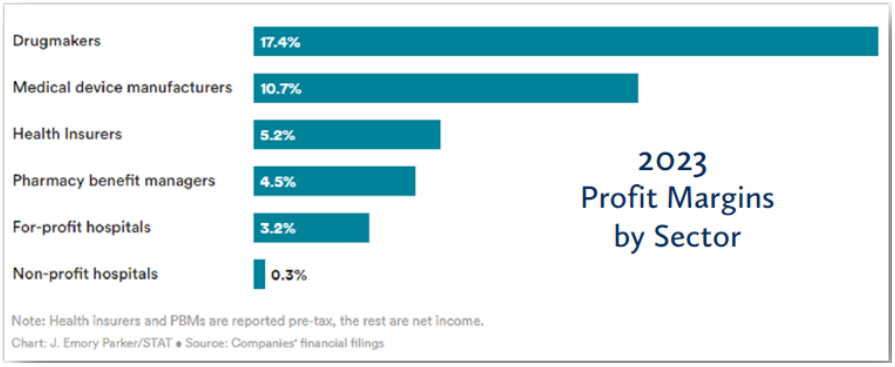
WHA has supported the concepts behind the Sustain 340B Act which was released as draft legislation in 2024. We appreciated your comments noting that HRSA's regulatory and enforcement authority has not kept up with the growth in the size of the 340B program. We are supportive of provisions in the Sustain 340B Act discussion draft that would provide HRSA with statutory clarity to enforce its longstanding policies allowing hospitals to receive 340B discounts for drugs dispensed at community pharmacies hospitals contract with. We also support providing HRSA with staffing resources it needs to improve program integrity.

While it is unclear what the current timeline for the Sustain 340B Act to be reintroduced is, we are currently reviewing recent 340B discussion draft legislation introduced by Senate HELP Committee Chairman, Bill Cassidy. We appreciate that it contains some protections for contract pharmacy arrangements. However, we also have concerns about what appears to be an expansion of the ability for drug companies to offer their discounts via rebates at their choosing. As was noted during our discussion, WHA members often have issues with drug companies abiding by current 340B maximum fair pricing rules, and do not have confidence they would abide by the 10-day time-limit established in HRSA's pilot or in this draft legislation.

WHA also cautions that while we understand policymakers' desire for more data on 340B, it is important to ensure such data collection is not unintentionally burdensome on health care providers. Hospitals are among the most regulated entities in the country, and already dedicate significant resources to 340B compliance. HRSA's annual audits currently cover four times as many hospitals as drug companies, and discussions related to 340B transparency for hospitals too often tend to lack the requisite transparency for drug company price setting, nor is the same scrutiny of what hospitals do with their 340B savings applied to what drug companies do with their immense profits.

2. Duplicate Discounts

WHA understands there is significant concern from drug makers and policy makers about potential duplicate discounts under 340B. We believe it is important to first of all recognize that, because the 340B discount program does not rely on any taxpayer funding (other than supporting HRSA's 340B operations) discussion about "fraud, waste, and abuse" concerning duplicate discounts has nothing to do with taxpayer dollars being at risk. Rather, it is really about whether drugmakers are paying discounts twice: once to a 340B covered entity like a hospital, and again to a state Medicaid program if the patient for whom the 340B discount is claimed is also a Medicaid patient. We fully recognize that drug makers are for-profit entities responsible to their shareholders who wish to maximize their profits. At the same time, making it more difficult for hospitals to access 340B discounts will only serve to limit resources and funding that hospitals use to care for communities.



Secondly, we would like to draw your attention to a study that was done recently by health economist and professor, Charles Courtemanche, for the Institute for the Study of Free Enterprise. The study estimated the overall number of duplicate discounts to be only 2.3% of all 340B fills[i]. While we understand drugmakers' incentive to eliminate duplicate discounts, we have supported a 3rd-party clearinghouse that would not add to the administrative complexity of the program or administrative burden of hospitals, and yet would accomplish the same objective. The current "fox guarding the henhouse" system that the pharmaceutical industry has created in 340B is unfair, putting themselves in a de-facto regulator position at the same time they maintain an incentive to maximize profits.

3. Drugmakers' Undisclosed Incentives for Rebates

Drugmakers have other incentives beyond ending duplicate discounts which explains their desire to transition the 340B program to a rebate model. Professor Charles Courtemanche's aforementioned study estimated the amount lost to duplicate discounts to be approximately $3.3 billion annually. However, ***he estimated they stand to gain a much larger benefit from transitioning to a rebate model, an estimated $9.3 billion annually, via other incentives***, including: avoiding paying valid claims, developing derivative data products, targeting and influencing health care providers, and selling data licenses.

It is these incentives that worry hospitals the most, as we are currently experiencing a parallel form of a rebate model in the health insurance sphere due to arcane health insurance prior authorization policies. Health insurers are incentivized to deny claims, backtrack on already approved services, and intentionally obfuscate coverage policies all in attempts to minimize claims for medical care and maximize their profits. Not only does this impact hospital revenue in terms of services provided that are ultimately not reimbursed, but hospitals expend significant time and administrative resources by clinicians that would be better spent on direct patient care. We are concerned that transitioning the 340B program to a rebate model would provide the same incentives to drugmakers to deny 340B rebates or set up other administrative burdens on hospitals, including, but not limited to the data collection they are seeking.

4. Invitation to tour hospital pharmacies in Wisconsin

Since we did not have the opportunity to have you visit in person, we would like to invite you to tour a WHA member hospital pharmacy or two the next opportunity you have to visit Wisconsin. We would like to have you meet with a small Critical Access Hospital pharmacy lead as well as a larger tertiary hospital pharmacy

lead. The complexity of the 340B program and administrative burdens of the program are best understood by seeing in-person the steps our 340B hospital pharmacy leads must take to successfully navigate the program. WHA's Vice President Federal Affairs and Advocacy Jon Hoelter will be reaching out to your team to coordinate scheduling.

Thank you again for joining WHA's Board to meet and discuss these important issues. As we mentioned during the meeting, we truly appreciate the important work HRSA does, not just in 340B, but also in relation to helping support our workforce needs. We look forward to continuing partnering with you and HRSA to improve health care delivery in Wisconsin.

Sincerely,

Brian Stephens
CEO, Door County Medical Center
WHA Board of Directors Chair

Imran Andrabi, MD
President/CEO, Froedtert ThedaCare Health
WHA Board of Directors Chair-Elect

Bob Van Meeteren
President/CEO, Reedsburg Area Medical Center
WHA Board of Directors Immediate Past Chair

Kyle O'Brien
President & CEO, Wisconsin Hospital Association

[i] Courtemanche, J., Charles. (2026). *340B Data from the ESP and Beacon Platforms Hold Considerable Value for Drug Manufacturers.* Institute for the Study of Free Enterprise, Working Paper 66. https://www.courtemanche.org/_files/ugd/520057_ecc908db5ca9460baa280a7dc89603a3.pdf