Washington State
Hospital Association

August 27, 2026

The Honorable Bill Cassidy, MD
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

Delivered electronically to 340bforpatients@help.senate.gov

Re: 340B Drug Price Integrity and Affordability for Patients Act Discussion Draft Legislation

Dear Chairman Cassidy:

On behalf of the Washington State Hospital Association (WSHA) and our more than seventy 340B-eligible hospital members, we respectfully submit the following comments on the 340B Drug Price Integrity and Affordability for Patients Act discussion draft legislation. The 340B Drug Pricing Program (340B program) is essential for the vulnerable patients who care is provided to by our safety-net hospitals. All participating hospitals are non-profit entities that serve the most vulnerable patients in their communities and meet strict eligibility requirements. These patients have complex medical needs and often have little to no insurance. They depend on our hospitals to find a way to meet their needs regardless of their insurance coverage.

WSHA shares the goal of ensuring the 340B program operates with transparency and accountability and would note the program currently publicly posts the results of the annual 340B covered entity audits. We would welcome the discussion around improvements. However, we are concerned that this proposed legislation does not uphold the core mission of the program and would not enable safety-net providers from continuing to "stretch scarce resources" and maintain or expand access to care for patients who face significant barriers. In WSHA's view, this is a one-sided proposal that does not seek to address concerns from all sides of the 340B program, and it comes at a time when a growing number of our 340B hospitals are near or operating in the red.

Covered entities at the local level are best equipped to determine community needs and how best to utilize the 340B program benefit. Since the program began, hospitals have been able to reinvest the savings into uncompensated care, behavioral health services, rural cancer treatment and other expanded rural specialty services, pharmacy services and other essential programs that would otherwise be difficult to sustain.

We support ensuring patients have access to their medications – and many covered entities utilize some 340B savings to provide free and reduced cost medications. However,

WSHA does not believe the 340B program should be limited to an artificial choice between a rebate model or limiting the benefit to patients as a sliding scale fee for medications. WSHA has significant concerns that several provisions, including the rebate provision, needlessly restrict hospitals' ability to meet their local community's needs. It is critical that any 340B program reforms preserve the flexibility hospitals need to respond to the unique needs of the patients they serve and uphold the intent of the program as it was created. Congress must ensure any program reforms do not undermine the financial stability of our nation's safety-net providers and decrease access to care.

We offer the following comments to ensure that reforms maintain and protect the intent of the program and advance access to care for millions of Americans.

1. **Drug manufacturers should not determine the 340B pricing model for covered entities and a rebate structure should not be added to statute.**
2. **Requiring all 340B discounts to be passed directly onto the patient with a statutorily set sliding scale fee schedule does not support patient access to comprehensive health care.**
3. **Contract pharmacy arrangements should be based on patient access and outcomes and not arbitrary numerical limits.**
4. **Congress must define "patient" in a way that reflects integrated health systems.**
5. **Reporting requirements should have parity between drug manufacturers and covered entities and be as minimally burdensome as possible.**
6. **Child-site restrictions and third-party administrator and contract pharmacy fee restructuring must not undermine a covered entity's ability to care for their community.**

Drug manufacturers should not determine the 340B pricing model for covered entities, and a rebate structure should not be added to statute.
This draft legislation allows manufacturers to initially choose how, and whether to, provide 340B savings to covered entities – retrospective rebates, discounts after submission of claims data to a clearinghouse, or upfront discounts only after the covered entity meets several conditions. As an overarching matter, drug manufacturers should not be involved in determining the 340B pricing model for covered entities. This allows drug manufacturers to unilaterally act as de-facto administrators of the program with little accountability or guardrails.

A rebate structure of the 340B program would be especially harmful for Washington's safety-net providers. When qualifying covered entities choose to participate in the 340B program, they anticipate reasonable administrative costs and structure staffing, operations, and program administration around an upfront discount model. Shifting to a fundamentally different discount mechanism would require new resources, imposing

unanticipated additional costs and administrative burdens on our hospitals. This would be particularly challenging if different manufacturers choose different pricing models, requiring the covered entity to comply with all three of the options.

These additional costs would harm all 340B entities but would have significant impacts on smaller, rural entities such as critical access hospitals. These hospitals already operate on thin margins and find it challenging to recruit and pay for staffing. This would be a significant additional cost to them and would jeopardize a program vital to supporting services in rural areas. The 340B program is especially vital given the expected reductions in payment expected under H.R. 1. These hospitals do not have the cash flow to be able to pay the wholesale acquisition cost upfront, then wait for a manufacturer to decide whether they will provide the rebate, and during the interim they are earning interest on full drug costs. Further, there is no clear timeline or detail about disputed claims that go to the Secretary for adjudication. This could leave covered entities with significant unpaid rebates for a substantial amount of time.

Requiring all 340B discounts to be passed directly onto the patient with a statutorily set sliding scale fee schedule does not support patient access to comprehensive health care.

Covered entities may alternatively receive an upfront discount for 340B-eligible drugs if they meet several conditions. We believe this structure creates a false sense of choice, and the conditions will substantially increase costs and administrative burden.

The 340B program at its inception was never intended to solely provide discounted drugs directly to patients. It was created to allow health care providers serving the nations' most vulnerable to "*resources as far as possible* (emphasis added), reaching more eligible patients and *providing more comprehensive services* (emphasis added)" in the face of rising drug costs. Many of Washington's 340B-participating hospitals do provide free and reduced cost medications to their patients. However, requiring *all* (emphasis added) discounts to be passed on *directly* (emphasis added) to the patient does not align with the statutory intent of the program or allow covered entities to best serve the needs of their patients.

For example, a central Washington 340B-participating hospital maintains two pharmacies in remote communities using the 340B benefit. Without these 340B-supported pharmacies, the communities would be pharmacy deserts. In rural Western Washington, another 340B-participating hospital utilizes the 340B benefit to support operating a free and low-cost dental clinic. These types of services are allowing safety-net providers to serve their community through both improved access to medications and services critical to patients' overall health and wellbeing. This legislative proposal to so extensively restrict the 340B benefit will harm patients, while allowing drug costs to continue to rise unconstrained.

Further, a significant amount of the 340B benefit for covered entities comes from commercial prescription claims. Patients with commercial insurance have fixed copays and are not the target demographic for providing discounted and free medications. This proposal would subsidize commercial insurance rather than truly benefitting patients.

The proposed requirement for upfront discounts would also require the reconfiguration of pharmacy billing and eligibility systems to implement income-based out-of-pocket caps across the system – an update that is not without substantial cost and administrative burden.

Congress should not pursue a provision allowing drug manufacturers to determine the 340B pricing model, nor should the rebate structure be added to statute. Covered entities should continue to receive upfront discounts and have the flexibility to determine how best to use the savings to meet local community needs.

Contract pharmacy arrangements should be based on patient access and outcomes and not arbitrary numerical limits.
Contract pharmacy use within the 340B program is already highly regulated to protect against duplicate discounts and diversion and is subject to HRSA audits. Contract pharmacies serve an important role of ensuring patients are able to receive their medications in the most accessible way to the individual. Arbitrarily setting a numeric limit for contract pharmacies will reduce patient access while doing little to address program integrity. These provisions are built on the faulty premise that hospitals are selectively choosing contract pharmacies. In reality, contract pharmacies are chosen based on where patients are accessing their medications and their insurance company's drug coverage.

This draft legislation includes a provision limiting the number of contract pharmacies a disproportionate share hospital (DSH), rural referral center, or freestanding cancer center may contract with. It would also limit contract pharmacies to the service area of the covered entity. Lastly, sole community hospitals and critical access hospitals would be the only hospital types permitted to utilize contracted mail-order pharmacies.

Washington is a largely rural and frontier state, with patients often traveling long distances to access care in urban or semi-urban centers. Most hospitals in Washington do not operate their own community retail pharmacies, instead relying on their pharmacy partners to meet the needs of patients where they live and work via contract pharmacy arrangements. Restricting contract pharmacies to the surrounding area of a 340B hospital is problematic in states like Washington, where a patient may live a large distance from where they are receiving treatment. This provision does not match patient preferences or lifestyles as patients may fill their prescriptions outside of a hospital service area. It would also effectively remove all specialty pharmacies as contract pharmacies. There are no primary specialty pharmacies located in Washington state. Pharmacy benefit managers

(PBMs) dictate where a patient must fill their medication, so there easily could be scenarios where even if a covered entity operates an in-house specialty pharmacy, the PBM will not allow the covered entity to fill the prescription for the patient.

Alternatively, in major urban centers serving a high number of Medicaid patients an arbitrary cap of five contract pharmacies severely limits patient reach. In a large city such as Spokane, five contract pharmacies likely does not fully capture all of the 340B hospital patients and the pharmacies where they are accessing their medications. The five contract pharmacy cap would also not allow 340B hospitals to meet the diverse pharmacy needs of their patients.

Oversight of contract pharmacy use can be achieved without arbitrary numerical caps. As we seek to improve the 340B program, policy decisions should be based on outcomes and not numerical counts.

Congress must define "patient" in a way that reflects integrated health systems.
The "patient" definition within this legislation is excessively limiting. WSHA supports defining a patient as someone who has received care from a covered entity within two years, either in-person or through telehealth services. However, limiting the definition of patient to only those who have received an *outpatient service* (emphasis added) and received a prescription from an employee or independent contractor of the covered entity does not account for integrated health system structures.

Specifically, a health system generally owns both hospitals and the medical groups, which treats patients in outpatient settings. The health care practitioners may be employees of the medical group. In the 340B program individual hospitals and child-sites, rather than the system, must meet the 340B program eligibility to be considered a covered entity. With this legislation's patient definition, patients of the medical group could be excluded.

Reporting requirements should have parity between drug manufacturers and covered entities and be as minimally burdensome as possible.
WSHA is not opposed to transparency reporting. Washington's own 340B state law[1] includes reporting requirements for both covered entities and drug manufacturers. The proposal does not reflect an appropriate level of parity between manufacturers and covered entities, as it imposes significant new restrictions on covered entities without corresponding obligations or accountability measures for drug manufacturers.

Requiring 340B drug-generated margin reporting will not reflect the true reality of hospital finances. 340B margins measure the 340B discounted drug purchasing - which fluctuates based on pricing set by drug manufacturers - relative to reimbursement. It does not

[1] E2SSB 5981 (2026)

necessarily demonstrate the profitability, or lack thereof, of delivering health care services, particularly those most prone to losses such as rural obstetrics, emergency departments and behavioral health services. Requiring this metric to be reported increases administrative burden while providing little transparency into the true financial status of hospitals.

Child-site restrictions and third-party administrator and contract pharmacy fee restructuring must not undermine a covered entity's ability to care for their community.
Hospital "child sites" or off-campus outpatient facilities, serve as essential community care sites across Washington. The child-site provisions in the discussion draft do not target fraudulent or opportunistic arrangements. By conditioning eligibility on rigid geographic, ownership, charity care, and Medicaid thresholds, they prohibit legitimate hospital off-campus outpatient clinics that provide critically needed services across Washington.

Specifically, an oncology clinic may serve a large number of Medicaid and low-income cancer patients but could be excluded from the program simply because the physical location is located in a zip code not designated as underserved. This incentivizes consolidation back to the main hospital campus, resulting in creating the exact access barriers the child sites are intended to prevent. The proposed child-site restrictions also disincentivize hospitals from investing in new clinics aimed at expanding access because their payer mix has not yet met the required volume thresholds.

Relatedly, limiting the fees paid to third-party administrators and contract pharmacies could hinder the number of companies willing to participate in the program. Contract pharmacies must maintain sophisticated systems to ensure program compliance. These obligations require investments in technology, staffing and oversight. Fee limitations fail to recognize the trust cost of maintaining ongoing compliance and operations.

Policies that reduce pharmacies' willingness to participate in 340B networks will disproportionately affect small and rural communities where pharmacy access is already fragile.

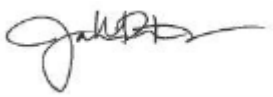
***

WSHA appreciates the opportunity to engage with Senator Cassidy and the Senate Health, Education, Labor and Pensions (HELP) Committee as it updates the 340B Drug Pricing Program. We would welcome the opportunity to discuss the critical importance of the 340B program to hospitals and the patients and communities they serve across Washington. Should you have any questions about our above recommendations, please contact Jacqueline Barton True, SVP Advocacy and Rural Health (JacquelineB@wsha.org)

or Remy Kerr, Policy Director, Government Affairs (RemyK@wsha.org).

Sincerely,

Remy Kerr, MPH
Policy Director, Government Affairs
Washington State Hospital Association



Jacqueline Barton True, MSW, MPH
Senior Vice President, Advocacy and Rural Health
Washington State Hospital Association

CC:
Senator Patty Murray (D-WA)
Senator Maria Cantwell (D-WA)