CONSUMER CHOICE CENTER

Comments submitted to 340bforpatients@help.senate.gov

Comments of the Consumer Choice Center

Senate HELP Committee 340B Drug Pricing Integrity and Affordability for Patients Act discussion draft

The Consumer Choice Center appreciates the chance to comment on Chairman Cassidy's 340B discussion draft.

CCC is a nonpartisan consumer advocacy group. We work on policies that lower the prices consumers actually pay.

We filed 340B comments with the Senate Finance Committee Minority Staff on August 17. Our position has not changed. There is a difference between lowering a price somewhere in the supply chain and lowering the price a patient pays. HRSA reports that 340B purchases reached about $100 billion in 2025. A program that size should be able to answer one question. Who benefits?

This draft answers it more directly than any earlier proposal. We comment only on provisions CCC has worked on before.

What the draft gets right

1. Section 2 verifies the discount before it transfers. Today eligibility is often decided after the patient already has the medicine. That makes duplicate discounts hard to catch. Section 2 fixes the order. It also meets the conditions we set out in August. Undisputed rebates are paid within 10 days. The data standard matches what covered entities already collect. Audits are paid for by the Secretary or the manufacturer. Disputes have a path to adjudication.

2. Section 2 also lets patients get the discount directly. A covered entity can pick its own mechanism if it passes every discount through to its 340B patients. It may keep a nominal dispensing fee. This is the strongest patient-facing provision in the draft. We asked why an eligible patient cannot see a share of a discount created in their name. This is an answer.

3. Section 4 makes eligibility checkable. It requires a care relationship, recent outpatient care, and a prescription from the entity's own practitioner. An auditor can verify all three. Vague eligibility is how the program drifted from its purpose.

4. Section 6 makes reporting comparable. CCC has called for standardized 340B reporting. Institutions should be compared, not described. Patient counts, costs, charity care, and margin are the right fields to start with.

5. **Section 7 caps what vulnerable patients pay.** A certified sliding fee scale ties the statutory discount to a real out-of-pocket limit. Transparency alone is not enough. This section adds the benefit.

We would add two reporting fields to Section 6. One is third-party administrator and contract-pharmacy fees. The other is the share of 340B savings that reached patients. Both are missing. Both are where the money is hardest to follow.

Section 9 uses a principle we have argued before

Section 9 requires third-party administrators and contract pharmacies to be paid a flat fee per service. Percentage-based pay is out.

CCC has made this argument about pharmacy benefit managers. Pay tied to a percentage rewards the middleman when the price goes up. A flat, disclosed fee removes that reward. The principle holds in a 340B contract pharmacy just as it does in a commercial formulary.

We support the flat fee structure.

Two adjustments

1. **Reconsider the 125 percent cap.** Section 9 also caps contract-pharmacy pay at 125 percent of that pharmacy's average dispensing fee. The flat fee rule is the real reform. The percentage is a price set by statute. CCC does not support setting prices that way when a structural fix works. Section 9 already requires fair market value and disclosure. Those should be enough.

2. **Tie contract-pharmacy limits to access.** CCC has said contract pharmacies can improve access. That is most true where a covered entity has no pharmacy of its own. Section 5 caps how many a covered entity may use. It also requires them to sit in the service area. A fixed cap could cut off rural patients and patients without transport. We suggest limits based on demonstrated access need. HRSA already receives registration, annual recertification, and copies of the written agreements. Those tools can police abuse.

Conclusion

This is the most serious 340B reform in fifteen years. Judge it by one standard. Does the patient see the discount?

On Sections 2 and 7, the answer is yes. That is a real change. We urge the Committee to keep those provisions, add the two reporting fields to Section 6, and reconsider the two provisions above.

Lower drug costs should mean lower costs **for patients**.

Respectfully submitted,

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Further reading: Consumer Choice Center on these issues

- 340B Drug Discount Program: Meant for the Poor but Benefitting Hospitals (Consumer Choice Center, February 2026). On retrospective verification, duplicate discounts, and why the discount so often stops short of the patient.
- Hospital Price Transparency Is a Missing Link in the Healthcare Affordability Debate (Consumer Choice Center, January 2026). On standardized disclosure that patients and employers can actually use.
- Both Parties Can Work Together to Lower Drug Prices (Consumer Choice Center). On why intermediary compensation tied to price distorts the supply chain.
- Comments of the Consumer Choice Center to the Senate Finance Committee Minority Staff Request for Information, August 17, 2026. On 340B transparency, patient-benefit standards, duplicate-discount safeguards, and biosimilar competitive neutrality.