August 28, 2026

The Honorable Bill Cassidy
Chair
U.S. Senate Committee on Health, Education, Labor and Pensions
428 Senate Dirksen Office Building
Washington, D.C. 20510

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

Dear Chairman Cassidy:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the policies included in the 340B Drug Pricing Integrity and Affordability for Patients Act Discussion Draft. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's (ACS) nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

As Congress considers policies to reform the 340B program, we would like to underscore that cancer is uniquely complex – it is not just one disease, it is more than 200 different diseases. Cancer patients often require evidence-driven personalized treatment regimens, and medications for cancer treatments are often not interchangeable during the course of a patient's treatment. Research and development have also progressed to the point where medications are often targeted to a specific subtype of cancer, driving better patient outcomes.

These drug therapies are the bedrock of cancer care, and ACS CAN has long fought for public policies that support both the affordability and availability of medically necessary prescription drugs. Making these therapies affordable, while continuing to encourage innovation of new treatments, is crucial to our mission. In the United States, there are approximately 18.6 million Americans who have a history of cancer, many of whom were diagnosed many years ago, and an estimated 2.1 million Americans who will be diagnosed with cancer in 2026.[1]

The affordability of oncology therapies remains a serious obstacle for many cancer patients. Even with health coverage, beneficiaries who need access to innovative cancer drugs may find their out-of-pocket costs running into the thousands of dollars each year. These added costs can force patients to forego or delay taking critical medications, which, for those battling cancer, can have serious health consequences. The cost of oncology medications can also force cancer patients to go into significant debt, even bankruptcy, to pay for their treatments.[2]

[1] American Cancer Society, *Cancer Facts & Figures 2026* (2026), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2026/2026-cancer-facts-and-figures.pdf.
[2] Id.

The 340B program is a critical lifeline in providing prescription drug access to vulnerable and low-income populations and enabling eligible entities to continue to serve these populations through deeply discounted drug prices. However, the current structure of the program and policy changes over the past 15 years have led to explosive growth of the program and abuses in which not all 340B revenues are being directed to those most in need in the form of discounted drug prices, lower out-of-pocket costs and charity care. We are concerned that the 340B program creates incentives for hospitals to use costlier medications,[3,4] which adds to the costs borne by cancer patients – the higher the cost of the drug used, the greater the amount cancer patients pay in cost sharing like deductibles and coinsurance.

Additionally, we are concerned that financial incentives from the 340B program may contribute to the ongoing consolidation of cancer care within the hospital setting, which is a higher-cost site of care, and may exacerbate access issues. Over the past decades, cancer care has increasingly shifted from community-based practices to hospital settings, many of which participate in the 340B program. Although several factors have contributed to this trend, the 340B program has been cited as a driver.[5] With 340B hospitals at a significant financial advantage due to the discounts they receive, independent practices may struggle to remain independent, further exacerbating hospital consolidation and driving up costs.

We appreciate the focus of this proposal to return the 340B program to its original congressional intent. The intent behind the original legislation, as stated in the House Report[6] accompanying passage of the law and adopted by the Health Resources and Services Administration (HRSA) as the purpose of the program, is to ensure that federal resources reach more eligible patients or provide more comprehensive services[7] by reducing the cost of medications that are critical to address the health needs of low-income patients.[8] Congress should ensure that reforms to the 340B program support patient access, address unintended incentives that contribute to provider consolidation and the selection of higher-cost drugs, and help ensure that program savings are meaningfully passed on to patients.

Section 4. Additional Definitions

This section would create new definitions for the terms “patient,” “outpatient health care service,” “practitioner,” and “specified nonhospital covered entity.”

ACS CAN supports efforts to clarify who would qualify as a patient for the purposes of the 340B program. A clear patient definition is critical for maintaining program integrity and preventing

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[3] U.S. Government Accountability Office (GAO), *Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals* (GAO-15-442, June 2015), https://www.gao.gov/products/gao-15-442.
[4] Milliman, *Assessment of Commercial Insurance Spending at 340B Hospitals* (September 2022), https://www.milliman.com/-/media/milliman/pdfs/2022-articles/9-13-22_phrma-340b-commercial-analysis.ashx.
[5] Nikpay, S., et al., “Association of 340B Drug Pricing Program Participation and Hospital Provision of Uncompensated Care,” *Health Services Research* 53, no. 6 (2018), https://doi.org/10.1111/1475-6773.12823.
[6] See H. Rep. No. 102-384, Pt. 2, at 12 (1992) (discussing bill to amend the Social Security Act).
[7] Id. “In giving these ‘covered entities’ access to price reductions the Committee intends to enable these entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”
[8] Congressional Budget Office, "Prices for Brand-Name Drugs Under Selected Federal Programs," June 2005.

inappropriate use of 340B discounts. As such, we encourage Congress to work with the Department of Health and Human Services (HHS) following enactment to monitor for appropriate application of these definitions to ensure that there are not any unintended consequences for patient access to care.

Section 6. Transparency

This section would require certain hospital-covered entities to annually report data such as the total number and types of individuals who received 340B drugs, total costs incurred, charity care, and margin generated from covered outpatient drugs. It would also require the HHS Secretary to publicly publish the data annually and issue rulemaking.

ACS CAN supports efforts to improve transparency in the 340B program and that would apply nationwide. Increased transparency on the program's utilization, patient reach, and financial impact could help to inform whether the program is accomplishing its intended goal of increasing access to expensive medications for low-income individuals. It is crucial that reforms to data reporting require HHS to publicly publish the results, providing stakeholders with greater visibility into the financial benefits hospitals and covered entities receive through 340B participation and the extent to which those benefits are used to support patients.

Section 7. Enhancing Affordability

This section would require hospitals participating in the 340B program to establish sliding-fee scales for low-income and uninsured patients to ensure that eligible low-income patients pay reduced out-of-pocket costs for 340B drugs.

ACS CAN supports 340B program reforms that enhance the affordability of prescription drugs, particularly for low-income patients, by better aligning the program with Congress's original intent to support safety-net providers and the patients they serve. Although manufacturers are required to provide discounts, there is no federal requirement that patients directly benefit from the savings. Studies show that a hospital's participation in the 340B program does not necessarily translate to greater amounts of charity care.[9] To make the program more patient-centered, Congress should also institute medical debt protections to ensure that entities receiving 340B revenue are providing financial assistance programs to low income, uninsured and underinsured patients, and not engaging in extraordinary collection activities when patients do incur debt with the facility.

While we support efforts to improve affordability, we encourage Congress to provide additional clarity on how these reforms would be implemented. Specifically, Congress should clarify how the sliding fee scale requirement under proposed Section 340B(a)(5)(G)(i) would operate alongside the covered entity election option, which allows entities to pass 340B savings directly to patients and then elect to receive the 340B price as a rebate or discount. Additionally, Congress should clarify how the sliding-fee scale would interact with existing patient cost-sharing obligations under private insurance. In particular, clarification is needed regarding who bears the financial responsibility when a patient's cost-sharing amount under the sliding-fee scale is lower than the amount required by their plan.

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[9] American Cancer Society Cancer Action Network (ACS CAN), *The Intersection of 340B and Cancer Care* (March 2025), https://www.fightcancer.org/sites/default/files/national_documents/340b_and_cancer_care_-_final_3-12-25.pdf.

Section 9. Contracting Reforms

This section would add new requirements for third-party administrator (TPA) fees and for contract pharmacy remuneration.

ACS CAN supports efforts to address misaligned incentives within the 340B program that enables intermediaries to profit from 340B revenue without providing corresponding benefits to patients. Many contract pharmacies are either owned by or contractually affiliated with major pharmacy benefit managers (PBMs), which often do not pass 340B savings to patients. Absent meaningful reforms, the program risks prioritizing revenue for middlemen over patient affordability, contrary to the program's original congressional intent.

Section 12. Application; Regulation and Guidance

This section would provide the Secretary with the authority to promulgate regulations and guidance to implement 340B, as needed.

ACS CAN supports providing HHS and HRSA with the authority to issue regulations and guidance related to 340B implementation. This reform would enable regulators to monitor program implementation and respond to program integrity concerns. Additionally, enabling formal rulemaking would promote transparency and help ensure that stakeholders, including patients, have the opportunity to provide input on policy changes.

CONCLUSION

Thank you for the opportunity to comment on the 340B Drug Pricing Integrity and Affordability for Patients Act Discussion Draft. If you have any questions, please feel free to contact me or have your staff contact Elizabeth Darnall, Senior Director, Federal Advocacy at Elizabeth.Darnall@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network