July 29, 2026

The Honorable Bill Cassidy, M.D., Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Bernie Sanders, Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

Dear Chairman Cassidy, Ranking Member Sanders, and Members of the Committee:

My name is Elbra Wedgeworth. I am the former President of the Denver City Council and former Vice President of Government and Community Affairs at Denver Health, Colorado's largest safety-net health system. Throughout my career, I have worked to improve access to health care and advance opportunities for underserved communities, including low-income patients, seniors, and communities of color.

I write on behalf of Save 340B, a Colorado-based coalition of patients, community leaders, advocates, and policy experts working to restore the federal 340B Drug Pricing Program to its original purpose: helping vulnerable patients access the medications and care they need.

During my years at Denver Health, I saw firsthand the indispensable role safety-net providers play in caring for vulnerable patients. I also came to understand that some hospitals are abusing the 340B program for profit instead of providing the assistance the program intended. Public trust requires accountability, which is why Save 340B strongly supports the Committee's July 1, 2026, 340B Discussion Draft. It is a serious and necessary response to a program that has drifted far from its statutory purpose.

The 340B program was created to help eligible safety-net providers stretch limited resources and improve patient access to affordable medicines. Instead, too many large hospital systems, contract pharmacies, third-party administrators, and pharmacy chains have turned 340B discounts into a revenue stream. They retain the value of discounts intended for vulnerable patients while patients continue to face high out-of-pocket costs at the pharmacy counter.

This is not an isolated administrative problem. It is a systemic failure of accountability. Hospitals and their intermediaries have exploited weak patient-eligibility rules, opaque virtual-replenishment practices, expansive contract-pharmacy networks, and loosely governed child sites to capture 340B revenue without demonstrating a corresponding patient benefit. The result is a multibillion-dollar system in which institutional and middleman profits too often come before patient affordability.

The Discussion Draft makes meaningful progress toward ending these abuses and restoring a patient-centered 340B program.

First, Save 340B strongly supports the requirement that covered entities, child sites, and contract pharmacies implement sliding fee scales that limit out-of-pocket costs for uninsured and low-income patients. Congress created 340B to help patients, yet federal law has never clearly required hospitals to share the resulting discounts with them. That must change. Every covered entity receiving 340B value should be required to provide direct, measurable affordability assistance to the patients whose care makes that value possible.

Second, Save 340B strongly supports a clear, nationwide rebate model as the preferred framework for the 340B program. A rebate model would replace the current opaque virtual-replenishment system with a transparent, auditable process that identifies the prescription, the eligible patient, the covered entity, and the value of the discount.

Against that backdrop, the Discussion Draft's rebate-pathway election is an important step forward. It appropriately rewards covered entities that pass the full value of the 340B discount directly to eligible patients, less an appropriate dispensing fee. It also creates a practical way to verify that discounts are tied to legitimate patient care rather than being retroactively captured through software-driven claims-harvesting arrangements.

The verification process must be prompt, reliable, and operationally simple. Hospitals that provide the required patient-eligibility and transaction information should receive timely rebates so that they do not face unnecessary financial burden or cash-flow disruption. A well-designed rebate model protects legitimate safety-net providers while preventing bad actors from using administrative delay as an excuse to preserve an unaccountable system.

A nationwide rebate model will also curb profit capture by contract pharmacies, third-party administrators, and other middlemen. It will make every transaction traceable, expose where 340B value is going, and prevent hospitals and intermediaries from claiming discounts on prescriptions that do not arise from a genuine, documented patient relationship.

Third, Save 340B supports the Discussion Draft's reforms to hospital child sites. Large systems should not be permitted to acquire independent specialty practices in affluent areas and convert them into 340B revenue centers. Requiring child sites to be located in medically underserved areas, meet Medicare provider-based standards, and demonstrate meaningful charity-care commitments will refocus 340B participation on communities with the greatest need.

Fourth, Congress should impose firm limits on contract-pharmacy arrangements and strengthen oversight of third-party administrators. Contract pharmacies have expanded dramatically, creating a sprawling system in which large retail chains and corporate administrators can profit from 340B transactions while patients receive little or no benefit. Limiting hospital contract pharmacies to five locations within the entity's service area is a sensible safeguard that keeps 340B resources connected to local patient care and makes oversight possible.

One issue in the draft we believe could benefit from more attention is the patient definition. A 340B-discounted prescription must be directly related to an outpatient service provided by the covered entity. Hospitals should not be able to claim 340B discounts on expensive specialty medicines merely because a patient had a remote or limited encounter with the institution.

Likewise, Congress should define and narrowly limit referrals. The legislation should require documented clinical coordination, a genuine ongoing care relationship, and written evidence from the treating specialist. These safeguards are necessary to stop referral capture and retrospective claims harvesting by hospitals, contract pharmacies, and third-party administrators.

Finally, the bill must include meaningful enforcement. Repayment of improperly retained discounts is not enough to deter deliberate exploitation of patient-eligibility rules. Covered entities and intermediaries that knowingly misuse the program should face significant civil monetary penalties and exclusion.

340B reform is not an attack on legitimate safety-net providers. It is a defense of the patients those providers exist to serve. Congress should preserve the program's purpose by requiring transparency, direct patient benefit, clear eligibility standards, and real consequences for abuse.

Thank you for your bipartisan leadership and for advancing a serious framework for comprehensive 340B reform. Save 340B looks forward to working with the Committee to strengthen the Discussion Draft and ensure that 340B discounts serve vulnerable patients—not hospital profit centers and corporate middlemen.

Sincerely,

Elbra Wedgeworth
Former President, Denver City Council
Executive Director, Save 340B