National Rural Health Association

November 9, 2026

The Honorable John Thune
Majority Leader
511 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Schumer
Minority Leader
322 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Mike Johnson
Speaker
521 Cannon House Office Building
Washington, D.C. 20515

The Honorable Hakeem Jeffries
Minority Leader
2267 Rayburn House Office Building
Washington, D.C. 20515

Dear Speaker Johnson, Leader Jeffries, Leader Thune, and Leader Schumer,

Manufacturer restrictions on contract pharmacy access, a looming shift from upfront 340B discounts to manufacturer rebates, and discriminatory practices by payers and pharmacy benefit managers are straining the 340B Drug Pricing Program lifeline that rural hospitals, clinics, and health centers depend on to keep their doors open and stretch scarce federal resources. The National Rural Health Association (NRHA) urges Congress to enact 340B reform that protects the program's original intent and strengthens, rather than undermine, rural patient access.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals (CAHs), clinics, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Rural hospitals operate on some of the thinnest margins in the health care system. Since 2010, 210 rural hospitals have closed or converted to a model that no longer provides inpatient care. Further, 41.2 percent of rural hospitals nationally are currently operating at a financial loss, and an additional 417 rural hospitals are presently vulnerable to closure.[1] Rural 340B hospitals face notably higher uncompensated care than their non-rural counterparts ($4,981 per discharge versus $2,965) and carry roughly double the cost-to-charge ratio of non-rural 340B hospitals (59% versus 29%), reflecting thinner markups and higher fixed costs.[2] 340B savings are often what keeps services such as obstetrics, behavioral health, and chemotherapy available in rural communities.

Hospitals are not the only rural providers that continue to struggle to stay afloat, but they are a proxy for the overall health of the rural health care system. Provider-based rural health clinics (RHCs), community health centers, and other covered entities rely upon the lifeline that is 340B to maintain the services most important to their patients and communities. Any reform that shifts cash-flow risk

[1] Michael Topchik, et al., 2026 Rural Health State of the State, Chartis Center for Rural Health (Feb. 10, 2026), https://www.chartis.com/insights/2026-rural-health-state-state.
[2] The National Grange; Avalere Health, Analysis of 340B Program Impact on Rural Hospitals (Feb. 6, 2026).

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onto covered entities or narrows who is considered a "patient" risk accelerating closures in the communities that can least absorb them.

Protect Rural Access.

NRHA believes in preserving the original intent of the 340B program to stretch scarce federal resources, and that providers are best situated to determine how 340B savings benefit their communities, without broad legislative or regulatory mandates. In practice, that means maintaining upfront discount pricing at the point of sale as the default mechanism for every covered entity. Upfront discounts let covered entities use their 340B savings immediately, while a rebate model forces providers to pay full price up front and wait for reimbursement, shifting cash-flow risk onto the rural safety net.[3] NRHA also urges Congress to include a clear statutory statement of the program's purpose to maintain, improve, and expand patient access to health care services by stretching scarce federal resources.

340B Rebate Model Pilot Program – *Health Resources and Services Administration, final notice effective January 1, 2027.* NRHA appreciates that the revised pilot's design reflects meaningful efforts to minimize impacts on covered entities, and we support its existing accommodations including manufacturer-borne IT costs, a 10-day prompt-payment window, unit-level rebate options, and transitional inventory allowances, which we urge Congress to adopt as a statutory floor for any rebate framework.[4] We remain concerned, however, with the underlying shift from upfront discounts to rebates for any covered entity, and we continue to urge HRSA to exempt small rural hospitals and clinics from rebate requirements by default. At minimum, CAHs, sole community hospitals (SCHs), rural disproportionate share (DSH) hospitals, and federally qualified health centers (FQHCs) should receive a delayed effective date or a simplified claims pathway. Rural facilities previously reported investing tens of thousands of dollars in pre-implementation compliance costs ahead of HRSA's now-rescinded 2025 rebate model, consistent with HRSA's own estimate of $34,320 per entity for claims process changes, illustrating the administrative burden that a mandatory rebate shift would impose on small rural covered entities.[5]

340B Rebate Model Delay Act (H.R. 10770) – *Reps. Rob Bresnehan (R-MI) and Debbie Dingell (D-MI).* NRHA supports this legislation to delay implementation of HRSA's 340B Rebate Model Pilot Program by two years, which would preserve upfront 340B discounts as the default purchasing mechanism during the delay period, require manufacturers to continue offering the 340B ceiling price as a direct reduction in purchase price rather than a rebate and bar HRSA from spending any funds to implement the pilot during the two-year pause. Passage of H.R.10770 would also allow for consideration of a rebate model as part of larger 340B program reform, rather than a one-off pilot program. FQHCs alone

[3] Sanofi Aventis U.S. LLC v. Becerra, 84 F.4th 106 (3d Cir. 2023).
[4] National Rural Health Association. Letter to Health Resources and Services Administration, Re: Implementation of the 340B Rebate Model Pilot Program (Oct. 6, 2026). https://www.ruralhealth.us/NationalRuralHealth/media/Documents/Advocacy/Letters%20to%20the%20Executive%20Branch/Letter-to-HRSA-on-Implementation-of-340B-Rebate-Model-Pilot-Program-2026.pdf
[5] Health Resources and Services Administration, *Notice Regarding 340B Rebate Model Pilot Program*, 91 Fed. Reg. (Aug. 3, 2026), https://www.federalregister.gov/documents/2026/08/03/2026-15633/notice-regarding-340b-rebate-model-pilot-program (estimating $34,320 per entity for claims process changes).

account for roughly 7% of 340B purchases nationally but serve more than 30 million patients per year.[6] A mandatory shift to rebates would impose hundreds of thousands of dollars in additional upfront drug costs on these safety-net providers, along with new data and information-technology burdens, and could force some to forgo stocking or prescribing certain drugs rather than absorb the lost savings.

SECURE 340B Act (H.R. 9599) – *Reps. Scott Peters (D-CA) and Dave Joyce (R-OH).* NRHA urges Congress to advance this legislative vehicle that pauses manufacturer rebates, consistent with our opposition to any mandatory shift away from upfront discounts.

Community Health Center Drug Pricing Protection Act (H.R. 7391) – *Reps. Jack Bergman (R-MI) and Jake Auchincloss (D-MA).* NRHA supports this bill's exemption of FQHCs from any future 340B rebate model and its protection of the 340B ceiling price for these providers.

SUSTAIN 340B Act (S. 5244) – *Sens. Jerry Moran (R-KS), Tammy Baldwin (D-WI), Shelley Moore Capito (R-WV), Tim Kaine (D-VA), John Boozman (R-AR), and John Hickenlooper (D-CO).* NRHA supports this bill's replacement of HRSA's rebate pilot with a national data clearinghouse. This would directly address our concerns about shifting cash-flow risk to rural providers. We urge Congress to ensure this clearinghouse is operated by an independent third party free of conflicts of interest with any 340B program participant, and that requests for claims-level data are not burdensome and are practicable for rural covered entities. Where a rebate mechanism advances in any form, we urge Congress to build in a default exemption for small and rural covered entities and place IT and administrative costs on manufacturers.

340B Drug Pricing Integrity and Affordability for Patients Act **Discussion Draft** – *Senate HELP Committee Chairman Bill Cassidy (R-LA).* NRHA urges Congress to reject the provisions under Section 2 of this discussion draft to extend a rebate framework program-wide and permanently, with no pilot period, phase-in, or evaluation checkpoint, unlike HRSA's own pilot, which is deliberately scoped to a narrow set of drugs with a mandatory first-year evaluation before any expansion.[7] NRHA does not believe a framework HRSA itself judged necessary to test narrowly first should be extended to the full program immediately, and we urge Congress to reconsider this provision, as well as the rebate model as a whole.

Rural 340B Access Act (H.R. 44) – *Reps. Jack Bergman (R-MI) and Debbie Dingell (D-MI).* NRHA urges Congress to enact this bill to add rural emergency hospitals (REHs) to the statutory definition of a covered entity for purposes of the 340B program, and to include REH eligibility in whichever 340B vehicle ultimately advances. The vast majority of rural hospitals and CAHs transitioning to an REH are either eligible to participate in or are participating in the 340B program. Continuation of 340B participation helps to sustain critical services in these outpatient-based rural facilities.

Contract Pharmacies.

[6] Advocates for Community Health, One-Pager: Cosponsor H.R. 10770, Delay Implementation of the 340B Rebate Model Pilot Program (2026) (noting that community health centers account for approximately 7% of 340B purchases nationally while serving more than 32.7 million individuals annually). https://www.congress.gov/bill/119th-congress/house-bill/10770

[7] Senate Committee on Health, Education, Labor, and Pensions, Discussion Draft, 340B Drug Pricing Integrity and Affordability for Patients Act, § 2 (Aug. 2026). https://www.help.senate.gov/340b-drug-pricing-integrity-and-affordability-for-patients-act-discussion-draftpdf

NRHA does not support any limitations on the number or location of contract pharmacies that rural covered entities can work with. Many rural covered entities are too small to support an in-house pharmacy and must rely on outside pharmacies. Given the geographic spread of rural areas, multiple contract pharmacies must be available to ensure rural access. NRHA members report using anywhere from two to ten contract pharmacies depending on the needs of their community and the geographic spread of their patient population. Additionally, mail order is not a substitute for rural patients who are frequently older and managing multiple prescriptions that require in-person assistance from a clinical pharmacist.

For example, one NRHA member hospital reported losing roughly half of its approximately $300,000 in monthly 340B contract pharmacy savings over three years due to growing manufacturer restrictions on contract pharmacies. Another saw a 38% decrease in 340B savings in a single year, and a community health center was forced to stop providing dental health services.[8] As of April 2026, a third of rural Medicare Part D beneficiaries live in a zip code with no pharmacy.[9] Any restrictions mean that a portion of rural patients will not maintain access to 340B drugs. Rural covered entities and their patients simply cannot face more barriers to care than they already do.

***340B Drug Pricing Integrity and Affordability for Patients Act* Discussion Draft** – *Senate HELP Committee Chairman Bill Cassidy (R-LA).* NRHA urges Congress to reject the proposed five-contract-pharmacy cap and Public Use Microdata Area service-area limitation in Section 5 of this discussion draft, which would cut off rural covered entities from the pharmacy relationships their patients depend on.[10] The entity pharmacy standard would hold hospital covered entities to a stricter physical "four walls" location requirement than contract pharmacies, which would eliminate entity pharmacy arrangements for multi-site rural hospital systems and push them into the draft's newly capped contract pharmacy limits instead. NRHA recommends the entity pharmacy standard for hospital covered entities instead be defined by the covered entity's service area.

340B Patients Act (S. 2372/H.R. 4581) – *Sens. Peter Welch (D-VT) and Jeff Merkley (D-OR), and Reps. Doris Matsui (D-CA) and Lori Trahan (D-MA).* NRHA supports the clarification that manufacturers must offer 340B discount pricing regardless of the manner or location in which a drug is dispensed, including through a contract pharmacy, and its bar on manufacturers conditioning 340B purchases on how or where a drug is dispensed, backed by civil monetary penalties for violations. These protections directly preserve the contract pharmacy access rural covered entities depend on.

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[8] NRHA documented similar member impacts in its response to the Senate 340B Bipartisan Working Group's earlier SUSTAIN 340B Act discussion draft, including one member hospital that lost roughly half of its approximately $300,000 in monthly 340B contract pharmacy savings over three years due to manufacturer restrictions, another that saw a 38% decrease in 340B savings in a single year, and a community health center that closed its dental health services following a reduction in 340B savings. Letter from the National Rural Health Association to the Honorable John Thune et al., Re: SUSTAIN 340B Act Discussion Draft (Apr. 1, 2024). https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/letters%20to%20the%20executive%20branch/nrha-sustain-340b-rfi-response-3-22-24.pdf

[9] Medicare Payment Advisory Commission, *Preferred Networks and Pharmacy Access in Part D* (Apr. 2026), https://www.medpac.gov/wp-content/uploads/2025/08/Tab-F-Pharmacy-Access-April-2026.pdf (finding that 33% of rural Medicare Part D beneficiaries live in a zip code with no pharmacy at all).

[10] Senate Committee on Health, Education, Labor, and Pensions, Discussion Draft, 340B Drug Pricing Integrity and Affordability for Patients Act, § 5 (Aug. 2026). https://www.help.senate.gov/imo/media/doc/340b_drug_pricing_integrity_and_affordability_for_patients_act_discussion_draftpdf.pdf#page=22

SUSTAIN 340B Act (S. 5244) *–Sens. Jerry Moran (R-KS), Tammy Baldwin (D-WI), Shelley Moore Capito (R-WV), Tim Kaine (D-VA), John Boozman (R-AR), and John Hickenlooper (D-CO).* NRHA urges Congress to codify current contract pharmacy access, consistent with this bill, including a bar on manufacturers conditioning 340B pricing on claims data reporting through manufacturer-run platforms.

Orphan Drugs.

NRHA supports relief from the orphan drug exclusion for CAHs, SCHs, and rural referral centers (RRCs). The exclusion uniquely disadvantages these rural hospital covered entities by allowing manufacturers to withhold 340B pricing for drugs with an orphan designation, including numerous high-cost therapies used in cancer care. Rural hospitals already face substantial challenges sustaining local oncology services, including low patient volumes, workforce shortages, specialized pharmacy requirements, reimbursement uncertainty, and the significant upfront cost of chemotherapy and other infused drugs.

The consequences for rural patients are significant. More than 450 rural hospitals eliminated chemotherapy services between 2014 and 2024,[11] forcing many patients to travel long distances repeatedly while undergoing cancer treatment. Although the orphan drug exclusion is not the sole cause of this decline, it compounds the financial barriers rural hospitals face when attempting to maintain or expand oncology services.

Congress should require manufacturers to provide 340B pricing for orphan-designated drugs purchased by CAHs, SCHs, and RRCs. Removing this inequitable exclusion would lower the cost of furnishing certain specialty treatments, help rural hospitals preserve local oncology capacity, and give rural patients more equitable access to lifesaving therapies closer to home.

Discrimination.

NRHA supports clear statutory restrictions on pharmacy benefit managers' (PBMs) and payers' ability to treat 340B participants differently. PBMs and insurance companies have increasingly discriminated against 340B patients, covered entities, and contract pharmacies, particularly problematic in rural areas, where PBMs restrict patient choice of pharmacy or location to receive infusion therapy.

PROTECT 340B Act of 2026 *– Reps. Doris Matsui (D-CA) and Tracey Mann (R-KS).* NRHA supports this bill's direct prohibition on group health plans, insurers, and PBMs, including Medicare Part D plan sponsors, their PBMs, and Medicare Advantage plans discrimination against 340B covered entities and the pharmacies that serve them. This exclusion would bar practices such as reduced reimbursement, discriminatory fees, clawbacks and chargebacks, heightened audit or inventory requirements, interference with a patient's choice of pharmacy, and refusal to contract based on 340B participation, and backed by civil monetary penalties of up to $5,000 per violation per day. These practices are especially harmful in rural communities, where patients may have few pharmacy options and may already travel significant distances to obtain medications or receive infusion therapy. We urge Congress to move this legislation forward as the most direct available vehicle for PBM and payer non-discrimination protections.

Oversight.

[11] Michael Topchik, et al., 2026 Rural Health State of the State, Chartis Center for Rural Health (Feb. 10, 2026), https://www.chartis.com/insights/2026-rural-health-state-state.

NRHA supports granting HRSA more oversight and regulatory authority over the 340B program. HRSA currently has limited ability to regulate the program and requires clear statutory authority, backed by adequate resources, including additional appropriations for audits, investigations, and oversight, to protect the program's integrity.

SUSTAIN 340B Act (S. 5244) *–Sens. Jerry Moran (R-KS), Tammy Baldwin (D-WI), Shelley Moore Capito (R-WV), Tim Kaine (D-VA), John Boozman (R-AR), and John Hickenlooper (D-CO).* We raise no objection to this bill's FY 2031 HRSA user fee start date on the order of 0.01% of program savings is small enough not to erode covered entities' overall savings while still equipping HRSA with adequate resources, and we support directing any additional appropriations toward HRSA's audit, investigation, and oversight functions.

Dispensing Fees.

NRHA believes restrictions should be put in place to prevent abuses from withholding program savings inconsistent with the intent of the law. Collection of large dispensing fees when dispensing 340B drugs puts undue stress and burden on small, rural providers.[12] These pressures come as rural communities are already losing pharmacy access. Between 2003 and 2021, the number of independently owned retail pharmacies declined by 16.1 percent in noncore rural areas and 9.1 percent in rural micropolitan areas, while increasing by 28.2 percent in metropolitan areas.[13] We urge Congress to set any dispensing fee cap at the actual cost of the time and materials associated with dispensing or defining it as market-based and fair, rather than an arbitrary ceiling. NRHA also urges Congress to recognize the costs low-volume, independent rural pharmacies reasonably incur and should be permitted to charge higher per-unit dispensing fees than high-volume national chains.

340B Drug Pricing Integrity and Affordability for Patients Act **Discussion Draft** – *Senate HELP Committee Chairman Bill Cassidy (R-LA).* NRHA supports Section 9's flat fee requirement on third-party administrators and contract pharmacies, which should help address excessive dispensing fees that have eroded 340B savings for rural providers. However, we request that rural pharmacies be exempted from the bill's 125% dispensing fee cap.[14] Rural independent pharmacies have already absorbed significant dispensing fee erosion from other payers and are closing at a rate that is deepening rural pharmacy deserts. Applying the cap uniformly risks driving rural contract pharmacies out of 340B participation altogether, eroding covered entities' savings and their ability to pass those savings on to patients.

Child Site Arrangements.

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[12] 340B Health, *Restrictions on 340B Contract Pharmacy Increase Drug Company Profits But Lead to Lost Savings, Patient Harm, and Substantial Burden for Safety Net Hospitals* (Mar. 2023). https://www.340bhealth.org/files/340B_Health_MANUFACTURER_340B_REBATE_MODELS_Report.pdf

[13] Lazaro E, Ullrich F, Mueller KJ. *Update on Rural Independently Owned Pharmacy Closures in the United States, 2003-2021.* Rural Policy Brief No. 2022-3. RUPRI Center for Rural Health Policy Analysis; August 2022. Accessed November 6, 2026. https://rupri.public-health.uiowa.edu/publications/policybriefs/2022/Independent%20Pharmacy%20Closures.pdf.

[14] Senate Committee on Health, Education, Labor, and Pensions, Discussion Draft, 340B Drug Pricing Integrity and Affordability for Patients Act, § 9 (Aug. 2026). https://www.help.senate.gov/imo/media/doc/340b_drug_pricing_integrity_and_affordability_for_patients_act_discussion_draftpdf.pdf#page=80

NRHA supports codifying HRSA's current child site guidance in the 340B statute. Maintaining child site access to the 340B program is essential for protecting rural patient access. Many rural hospitals operate offsite locations, such as provider-based rural health clinics and these locations must be able to continue to serve as access points for rural 340B patients.

SUSTAIN 340B Act (S. 5244) *–Sens. Jerry Moran (R-KS), Tammy Baldwin (D-WI), Shelley Moore Capito (R-WV), Tim Kaine (D-VA), John Boozman (R-AR), and John Hickenlooper (D-CO).* As outlined in this bill, NRHA urges Congress to retain existing Medicare provider-based guidelines as the eligibility framework, since rural covered entities are already familiar with these requirements, rather than layering on additional, unfunded requirements.

340B Drug Pricing Integrity and Affordability for Patients Act **Discussion Draft** – *Senate HELP Committee Chairman Bill Cassidy (R-LA).* NRHA is pleased to see Section 8 codify HRSA's existing child site guidance, including a helpful grandfathering provision for shortage-area designations made before the specified date. However, Section 8's new charity-care and Medicaid/CHIP outpatient revenue-share thresholds are new financial tests not found in current HRSA guidance and will likely difficult for a small rural provider-based clinic to track or satisfy against a statewide hospital benchmark that may not reflect local conditions.[15] We recommend either removing these two new thresholds or providing a simplified compliance pathway for child sites of CAHs, RHCs and other rural 340B-participating facilities.

Patient Definition.

NRHA supports HRSA's 1996 definition of a patient,[16] with the addition of allowing telehealth services to count as patient visits for covered entities in rural areas. This guidance must be codified in the 340B statute to provide clarity, and the statute should make clear that covered entities may claim prescriptions from a referring provider where the covered entity retains ultimate responsibility for the patient's care. NRHA urges Congress to codify a patient definition that reflects how rural medicine is practiced by using an encounter-based standard that explicitly counts telehealth visits, seasonal and migrant populations, and referral relationships in which the covered entity retains clinical responsibility, without requiring a formal contract.

340B Drug Pricing Integrity and Affordability for Patients Act **Discussion Draft** – *Senate HELP Committee Chairman Bill Cassidy (R-LA).* Section 4's "practitioner" definition is narrower than how rural care is actually delivered. It requires a formal, ongoing contractual relationship between a covered entity and a referring provider, when many rural covered entities rely on informal referral relationships in which they retain ultimate clinical responsibility for the patient.[17] NRHA does not support this narrow definition.

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[15] Senate Committee on Health, Education, Labor, and Pensions, Discussion Draft, 340B Drug Pricing Integrity and Affordability for Patients Act, § 8 (Aug. 2026). https://www.help.senate.gov/imo/media/doc/340b_drug_pricing_integrity_and_affordability_for_patients_act_discussion_draftpdf.pdf#page=67

[16] Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility, 61 Fed. Reg. 55,156 (Oct. 24, 1996). https://www.hrsa.gov/sites/default/files/hrsa/opa/patient-entity-eligibility-10-24-96.pdf

[17] Senate Committee on Health, Education, Labor, and Pensions, Discussion Draft, 340B Drug Pricing Integrity and Affordability for Patients Act, § 4 (Aug. 2026).

SUSTAIN 340B Act (S. 5244) *–Sens. Jerry Moran (R-KS), Tammy Baldwin (D-WI), Shelley Moore Capito (R-WV), Tim Kaine (D-VA), John Boozman (R-AR), and John Hickenlooper (D-CO).* NRHA urges Congress to ensure the two-year outpatient lookback governing the statutory patient definition outlined in this bill accounts for ongoing rural referral relationships and includes telehealth encounters, consistent with how rural care is delivered.

SECURE 340B Act (H.R. 9599) *– Reps. Scott Peters (D-CA) and Dave Joyce (R-OH).* NRHA has concerns on Section 2's patient definition to require a documented provider-to-patient relationship with clinical responsibility or oversight by the prescribing provider within a 24-month lookback, and which limits the referral pathway to FQHC patient-centered medical homes, CAHs, and SCHs, would leave out rural referral centers and rural DSH hospitals. Furthermore, NRHA is concerned that this definition may not fit the informal referral relationships through which rural care is delivered. NRHA asks Congress to extend a referral pathway to all rural covered entities that retain clinical responsibility for the patient, without requiring a formal contract and to expressly count telehealth encounters toward the lookback, so that covered entities are not navigating conflicting definitions. A new statutory patient definition should reflect these same rural referral and telehealth considerations, so that covered entities are not navigating three different definitions depending on which bill ultimately becomes law.

Reporting Requirements.

NRHA encourages limits on program reporting and supports data collection only insofar as it uses data that entities are already reporting in another federal program. Rural hospitals and FQHCs are already required to report data demonstrating community benefit for many federal programs, and rural covered entities have limited capacity to comply with additional unfunded mandates for reporting on 340B savings.

340B Drug Pricing Integrity and Affordability for Patients Act **Discussion Draft** *– Senate HELP Committee Chairman Bill Cassidy (R-LA).* NRHA supports Section 6's tiered reporting structure, which relies on data already captured in Medicare cost report worksheets. Because the thresholds are set at $200 million and $1 billion in net patient revenue, NRHA believes most small rural hospitals would fall into the lightest tier or outside its scope entirely. NRHA urges Congress to confirm that reading and to ensure implementing regulations do not inadvertently sweep small rural DSH hospitals through the revenue-calculation methodology. Our full section-by-section views of this discussion draft are in our comment letter submitted in late August.[18]

NRHA thanks you for your efforts on these important vehicles and for the opportunity to share our priorities. We look forward to working with Congress to see 340B reform move forward in a way that benefits rural patients and the providers who care for them, and we stand ready to provide additional data or member examples on any of the items above. If you have any questions or wish to discuss further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

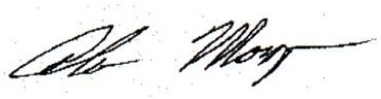
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[18] Senate Committee on Health, Education, Labor, and Pensions, Discussion Draft, 340B Drug Pricing Integrity and Affordability for Patients Act, § 6 (Aug. 2026). https://www.help.senate.gov/imo/media/doc/340b_drug_pricing_integrity_and_affordability_for_patients_act_discussion_draftpdf.pdf#page=43

National Rural Health Association

Sincerely,



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