

**Statement
of the
American Hospital Association
for the
Committee on Health, Education, Labor and Pensions
of the
United States Senate
“The 340B Program: Examining Its Growth and Impact on Patients”
October 23, 2025**

On behalf of our more than 2,000 member hospitals and health systems that participate in the 340B Drug Pricing Program, the American Hospital Association (AHA) writes to express our strong support for this vital program that allows eligible hospitals to maintain, improve and expand access to essential services and medications for the patients and communities they serve.

The 340B program was established by Congress in 1992 with broad bipartisan support with a clear and simple purpose: to enable hospitals and other safety-net providers that care for a disproportionate share of low-income and uninsured patients to stretch limited federal resources and reinvest savings into expanding access to care to more patients without using any taxpayer dollars. In effect drug companies are incentivized to offer discounts on certain outpatient drugs in exchange for coverage of these drugs by Medicaid and Medicare, often the largest purchasers of these drugs.

Eligible hospitals use the savings generated from their participation in the 340B program in many ways to advance access to care. For example, hospitals use their savings to provide access to free or discounted medications for low-income patients. Hospitals also use the 340B discounts to support the expansion of existing services and the



creation of new programs and services to the direct benefit of the patients and communities they serve. For instance, 340B savings are used to provide financial assistance to patients unable to afford their care; fund other medical services, such as obstetrics, diabetes education, oncology services and other ambulatory services; provide clinical pharmacy services, such as disease management programs or medication therapy management; establish additional clinics to meet community needs and bring access to otherwise unprofitable service lines; and create new community outreach programs.¹

In addition to these benefits, the 340B program has been a critical support for participating hospitals to defray the rising cost of drugs, which contributes to the overall increases in the costs that hospitals incur in caring for patients. For example, a recent report from this Committee highlighted the fact that 688 drugs this year alone have experienced price increases, with a median price increase of 5.5%, well above the rate of inflation.² The 340B program has helped to keep drug prices lower than they otherwise would be as the law requires drug companies to provide deeper discounts the more they increase their prices. Moreover, these savings have helped 340B hospitals, which treat a disproportionate share of the nation's Medicare and Medicaid patients, subsidize chronic underpayments from these government payers and maintain access to care in the face of ongoing financial challenges. In fact, based on fiscal year (FY) 2023 Medicare cost report data, nearly 44% of 340B hospitals operated on a negative margin. Importantly, if not for the 340B program, hospitals' margins would be even lower as there would be no 340B savings to offset government underpayments. Furthermore, the programs and services supported by 340B would either cease to exist or would require taxpayer dollars to support. Therefore, the 340B program helps keep government health care spending lower than it would be otherwise.

It also is important to highlight that the benefits of improved access to care are felt not only by the hospital's uninsured and low-income patient population, but also by the entire community the hospital serves. In 2022, tax-exempt hospitals participating in the 340B program provided nearly \$100 billion in total community benefits, including financial assistance, unreimbursed Medicaid costs, mental health services, chronic disease management and transportation support for patients without access to care. This represents a 47% increase in community benefit spending since 2019. Moreover, with sales in the 340B program to hospitals estimated to be \$46.5 billion in 2022, this means that for every dollar in 340B drug sales, hospitals provided over \$2 in benefits to their communities. This outsized level of commitment to the communities that 340B hospitals serve would not be possible without support from the 340B program.

The 340B program is especially critical in rural America, where 340B serves as a lifeline that helps preserve access to care for the over 60 million people living in rural communities. Nearly half of rural hospitals deliver care significantly below the cost of

¹ <https://www.aha.org/340b-case-studies>

² <https://www.help.senate.gov/dem/newsroom/press/news-sanders-report-finds-nearly-700-prescription-drugs-have-increased-in-price-under-trump>

providing services, making it financially challenging to remain viable. Many are facing risks of closure due to low patient volumes, high fixed costs, outdated infrastructure and workforce shortages. For example, 48% of rural hospitals operated at a financial loss in 2023, and over 100 have closed or converted in the last decade.³ Most rural hospitals lose money when providing critical medical services needed in their communities and therefore rely on 340B savings to remain operational and provide specialty care.⁴ If these services were unavailable in their communities, rural patients would be forced to drive far distances to access the same level of care, which for many would be impossible.

Despite the 340B program's many benefits, opponents often suggest that it has grown "out of control" and is not operating consistent with congressional intent. These accusations are not based on real evidence. For example, a recent Congressional Budget Office (CBO) report suggested that "the 340B program encourages behaviors that tend to increase federal spending," but later admitted: "In many cases, the evidence about the behaviors is limited, and the magnitude of their effects is unknown. CBO has not estimated how legislation affecting those behaviors would alter federal spending." Thus, absent any real evidence, the report draws broad, unsubstantiated conclusions about the 340B program.

In addition, 340B often is falsely accused of being a driving factor of hospital acquisitions of physician practices. However, data shows commercial insurers and corporate entities continue to play an outsized role when compared to hospitals in reshaping the physician acquisition landscape. Over the past five years, commercial health insurers have acquired 40% more physicians than hospitals and corporate entities have more than doubled the total number of physicians acquired.⁵

Ultimately, these unsupported allegations about the growth and impact of the 340B program have become the basis for repeated attempts to scale back the program at the expense of Americans nationwide. These misimpressions in the public narrative have undergirded efforts to fundamentally change how 340B hospitals access 340B discounted pricing from an upfront discount to a back-end rebate and impose arbitrary restrictions on accessing 340B pricing through partnerships between 340B hospitals and community pharmacies. If allowed, these changes to the program would delay access to medications, increase administrative costs, and undermine the financial stability of the hospitals that the program is meant to assist.

It is important to get the facts straight. While the 340B program has experienced growth since its inception over 30 years ago, this expansion is in large part a result of

³ <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>; converted facilities no longer offer inpatient services but continue to provide some health care services.

⁴ AHA analysis of industry benchmark data from Strata Decision Technology LLC.

⁵ <https://www.aha.org/system/files/media/file/2025/10/who-is-really-driving-physician-acquisitions-infographic.pdf>

congressional decision to expand it, which itself was a recognition of the program's success. For example, in 2010, Congress expanded the benefits of the 340B program to many rural hospitals to improve health care access to more low income and uninsured patients. Those hospitals included critical access hospitals, rural referral centers, sole community hospitals and free-standing cancer hospitals. Similarly, the first Trump Administration, in a Dec. 30, 2020 memo from the Department of Health and Human Services, made the wise decision to permit the expanded use of contract pharmacies so that patients — especially in rural areas — could access drugs closer to their home. What's more, several other factors have contributed to the program's growth, including regulatory changes hastening the shift of many services from the inpatient setting to the outpatient setting, increased development and reliance on high-cost specialty drugs, and the persistent and skyrocketing growth of drug prices. Importantly, as the program has grown in size, so have the benefits to communities made possible by the 340B program.

The 340B program continues to fulfil Congress' intent when it established the program over 30 years ago and expanded it 15 years ago. Importantly, the flexibility the law affords each 340B hospital to determine how to use its savings to address the unique health care needs of the patient populations it serves remains a critical feature of the program that has enabled its success. Thus, we ask Congress to maintain its commitment to the 340B program and the patients and communities that benefit from it.

We appreciate the HELP Committee's continued interest in this vital program, and we look forward to working with the committee to protect and support the 340B program and the benefits it affords to countless vulnerable patients and communities across the country.