Catholic Health Association of the United States

We Will Empower Bold Change to Elevate Human Flourishing.℠

October 22, 2025

The Honorable Bill Cassidy, M.D.
Chair
U.S. Senate Committee on Health, Education, Labor, and Pensions
Washington, D.C.

The Honorable Bernie Sanders
Ranking Member
U.S. Senate Committee on Health, Education, Labor, and Pensions
Washington, D.C.

Dear Chairman Cassidy and Ranking Member Sanders,

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of the Catholic health ministry, representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations across the continuum of care, I would like to take this opportunity to express our views for the Senate HELP Committee hearing on "The 340B Program: Examining Its Growth and Impact on Patients."

Catholic health care is the largest not-for-profit provider of health care services in the nation, with over 674 hospitals. Last year, Catholic hospitals provided care to one in seven patients, employed approximately 700,000 people, and had more than five million admissions. As frontline health care facilities guided by the teachings of the Catholic Church, CHA and its members are committed to respecting the human dignity of each person, promoting the common good, showing special concern for low-income and other vulnerable persons, and being responsible stewards of our resources. These foundational beliefs drive our long-standing commitment to ensure that every patient has access to quality care regardless of ability to pay. The 340B program plays a crucial role in enabling nearly 350 Catholic safety net hospitals to fulfill their commitments to serving their communities.

Purpose of 340B Program:

Section 340B of the Public Health Service Act requires pharmaceutical manufacturers that participate in the Medicaid program to provide covered outpatient drugs at a discounted rate to safety net and other health care facilities serving low-income, vulnerable communities or remote rural areas. Congress created the program in response to the high pharmaceutical costs faced by safety-net hospitals. The intent was "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[1] The significant pharmacy discounts available under the program enable hospitals to continue providing and expanding community services that would otherwise be unavailable to these populations.

For example, savings from the 340B program allow providers to run free and low-cost clinics; provide services in remote or low-income areas; offer generous financial aid policies; provide low-cost or free prescriptions; maintain critical services that operate at a loss; and support community programs

[1] "340B Drug Pricing Program - Official website of the U.S. Health Resources & Services Administration". Hrsa.gov. retrieved 20 October 2025. See H. Rep. No. 102-384, Pt. 2, at 12 (1992); See also Veterans Health Care Act of 1992, Pub. L. No. 102-585 § 602, 106 Stat. 4943, 4967-4971 (1992).

meeting the identified needs of their service areas.

As a result, 340B disproportionate share hospitals (DSHs) continue to serve a greater share of patients with low incomes and other characteristics indicative of their safety-net roles.[2] These hospitals provide 67% of all such care, representing only 44% of all hospitals. Despite the numerous financial challenges facing hospitals, the 340B program is a lifeline for those serving disproportionate shares of Medicaid and uninsured patients, fulfilling the goal of the program to strengthen the health care safety net without additional taxpayer cost.

Strengthen the 340B Program

We support measures to strengthen the 340B program, consistent with its original intent: to enable safety net and rural hospitals to serve more people and provide more comprehensive services by providing these hospitals with access to lower-cost outpatient drugs.

One area in which the 340B program has played a critical role in expanding and supporting access to care is through the use of contract pharmacies. These pharmacies play a crucial role in ensuring patients have access to the medications they need, particularly in rural communities. These arrangements with 340B providers and community and specialty pharmacies have been recognized by HRSA since 1996 and serve as a crucial tool for enabling patients to receive medications without having to travel long distances to pick up prescriptions. The recent growth in contract pharmacy and child site arrangements has been a lifeline for the health safety net, as providers face continued financial challenges in maintaining services in hard-to-reach and low-income communities. The growth also reflects, in part, the changes in HRSA's registration guidance and reporting requirements, which have led to an increase in the number of registered states, but do not represent an actual expansion of services or acquisitions.

These contract pharmacies also promote patient access by allowing hospitals to provide patients access to drugs that may be in limited distribution or supply. These contract pharmacy arrangements are particularly critical for rural health providers, where access to pharmacies is more limited and where 340B providers already face significant financial hurdles in maintaining and expanding lines of services.

Despite the success of the 340B contract pharmacy arrangements in expanding access to necessary medications, drug manufacturers continue to litigate and restrict access to 340B contract pharmacies. As a result, providers and patients face significant financial and logistical challenges, and providers in rural and low-income communities face extreme pressure to keep facilities open and maintain lines of service. We would urge Congress to support HRSA's efforts to protect these contract pharmacy arrangements by further clarifying protections for contract pharmacy arrangements in the federal 340B statute.

HRSA currently has significant authority to oversee the implementation and integrity of the 340 B program. For 340B covered entities, these program integrity requirements include an annual

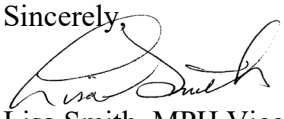
[2] 340B Health. State Level Reports: 340B DSH Hospitals Serve a Greater Share of Patients with Low-Incomes and Other Characteristics Indicative of Their Safety-Net Roles. https://www.340bhealth.org/members/research/state-level-reports/ .

recertification for 340B providers and an ongoing process for covered entities to evaluate and correct aspects of their 340B program. Additionally, covered entities such as hospitals are subject to audits of their 340B programs by HRSA and drug manufacturers. As a result of these requirements, HRSA has conducted audits of 1,720 340B health care providers since 2012.

Lastly, Catholic health care providers have not only met these requirements but gone above and beyond them by participating voluntarily in the AHA Good Stewardship Principles, demonstrating how 340B savings benefit their patients and communities.

Thank you again for the Committee's attention to this essential program. As you move forward, please always bear in mind the communities, facilities, and individuals that rely on 340B for continued access to the health care they need. If you have any questions, please feel free to reach out to me or Lucas Swanepoel (Lswanepoel@chausa.org)

Sincerely,



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