Statement for the Record
by the
Association of American Medical Colleges
for the
Senate Health, Education, Labor, and Pensions (HELP) Committee
"The 340B Program: *Examining Its Growth and Impact on Patients*"

October 23, 2025

The AAMC[1] appreciates the opportunity to submit this statement for the record to the Senate HELP Committee hearing, "*The 340B Program: Examining Its Growth and Impact on Patients*." The AAMC and our members are committed to ensuring the long-term sustainability of the 340B program for covered entities and the patients and communities they serve. We want to work with the committee to explore meaningful policy solutions that ensure that the 340B program is operating according to Congress' original and stated intent – to help covered entities "stretch scarce federal resource as far as possible, reaching more eligible patients and providing more comprehensive services."

Most AAMC-member teaching hospitals qualify for 340B eligibility based on their status as safety-net providers in their local communities, as measured by their Disproportionate Share Hospital (DSH) adjustment percentage. Although they comprise just 5 percent of hospitals, our members account for 29% of Medicaid inpatient days and 33% of hospital charity care costs.[2] Beyond the inpatient setting, academic health systems and teaching hospitals' outpatient departments (HOPDs) care for more medically and socially complex patients, such as Medicare-Medicaid dual eligibles and people with disabilities.[3] The 340B program, which allows safety-net providers to purchase outpatient drugs at a discount from pharmaceutical manufacturers, helps to support our members' continued ability to care for these rural and underserved patients while supporting other vital programs and services.

In addition to their unique patient mix, academic health systems and teaching hospitals deliver a wide range of services that are otherwise unavailable in other settings, from trauma and burn units to neonatal intensive care, oncology treatment, and transplant services.[4] Academic health systems are often the sole source of this care, especially in rural and underserved communities. Many of these services – such as labor and delivery, substance use disorder treatment, and

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[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 14 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

[2] Source: AAMC analysis of AHA Annual Survey Database FY2023 and NIH Extramural Research Award data. Note: Data reflect all short-term, general, nonfederal hospitals.

[3] Source: AAMC Analysis of 2021 5% Medicare Standard Analytic Files

[4] AAMC Research and Action Institute, Clinical Benefits of Not-for-Profit Health Systems Beyond Charity Care, https://www.aamc.org/advocacy-policy/clinical-benefits-not-profit-health-systems-beyond-charity-care

inpatient psychiatric care – generate little to no margin, potentially making them among the first to be impacted when hospitals face financial troubles. Academic health systems and teaching hospitals are more likely than their non-teaching counterparts to offer these vital (albeit, under-reimbursed) services, further highlighting their critical role as safety-net providers in their communities, and often, the only resource in rural communities. Absent 340B savings, it would be far more difficult for our members to support these service lines, potentially restricting access to life-saving care in communities nationwide.

Now more than ever, AAMC-member teaching hospitals rely on the 340B program to support their missions of patient care, physician training and education, medical research, and community collaboration. Our members are operating under severe financial pressures as they grapple with historic workforce shortages, inadequate reimbursement from public payers, supply chain disruptions, and rising expenses (including drug costs). According to the Medicare Payment Advisory Commission (MedPAC), hospitals' overall fee-for-service Medicare margins dropped to a record low of -11.6 percent in 2022, and this downward trend is expected to continue.[5] These challenges are expected to be further exacerbated by policies contained in the recently passed One Big Beautiful Bill Act (OBBBA, P.L. 119-21). In particular, the law's newly enacted restrictions on state-directed payments are expected to disproportionately harm teaching hospitals and academic health systems, which are a crucial – and in some cases, sole – provider of specialty and sub-specialty care for the Medicaid population. Furthermore, the law's new restrictions on Medicaid eligibility and enrollment are expected to increase the number of uninsured patients nationally, increasing the uncompensated care burden placed on our members. Taken together, these circumstances mean that our members will be expected to do more with less in the coming years. Preserving the 340B program is an effective and appropriate way to help hospitals navigate this transition period, at little cost to the federal government.

With regards to the Congressional Budget Office's recent analysis of 340B program, the AAMC fundamentally disagrees with the assumptions underpinning the agency's assertions regarding 340 program's recent growth and impacts on federal spending. While the CBO report asserts that the 340B program incentivizes vertical integration – and by extension, increases federal spending – there is compelling evidence that the recent growth in child sites reflects changing registration policies, rather than hospitals' acquisition of clinics. Furthermore, the CBO report asserts that the program increases federal spending by incentivizing hospitals to prescribe more drugs and shift to more expensive drugs. Their analysis ignores peer-reviewed evidence to the contrary – studies concluding that 340B hospitals do not significantly differ from their non-340B counterparts in their prescribing patterns. Finally, it is worth noting that to qualify for covered entity status, a hospital must care for a certain number of low-income Medicare and Medicaid patients, meaning that they are highly reliant upon public payers. Without 340B support, these public payers would likely need to step in and provide additional financial assistance to these institutions, or else risk their closure, which would ultimately *increase* federal spending rather than reduce it.

[5] Medicare Payment Advisory Commission, December 2023 Report, https://www.medpac.gov/wpcontent/uploads/2023/03/Hospital-Dec-2023-SEC.pdf

Further, the CBO report contends that 340B tends to increase federal spending because facilities use the savings generated through 340B to expand their service offerings. The AAMC would argue that this reflects a *function*, not a flaw, of 340B, and furthermore, that increased access to preventive care can help to reduce federal health care spending over the long term. As you know, Congress first created the program in 1992 to help covered entities "stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." Therefore, helping health care organizations "provide more comprehensive services" and increasing patients' access to care is an explicitly stated goal of the program. This is true at AAMC-member academic health systems and teaching hospitals, where 340B helps to maintain and expand critical service lines like labor and delivery and psychiatric care, especially in rural and underserved communities.

CBO asserts that because expanded services may be covered by public payers like Medicare and Medicaid, they are associated with an increase in federal outlays. However, unless Congress intends to eliminate access to these services entirely – which would have disastrous consequences for the health of patients and communities – these public programs would be reimbursing for these services regardless of 340B's existence. Also, as CBO acknowledges in their report, these expanded services may result in expanded access to preventive care and improved health overall, which would result in patients requiring "less costly care" and produce savings over the long term. Finally, without the discounts provided by 340B, hospitals would be faced with rising drug costs, forcing them to negotiate higher reimbursement from commercial payers (which would also increase federal outlays in the form of premium assistance), or else seek additional support through Medicare and Medicaid (which would also increase federal spending). In short, expanded service offerings made possible by 340B benefit patients' health and are not necessarily associated with increased spending over the long term.

The AAMC appreciates the HELP committee's continued interest in protecting the health care safety-net and remains committed to working with the committee to preserve and improve the 340B program. If you have any further questions, please contact AAMC Senior Director of Government Relations and Legislative Advocacy, Len Marquez, at lmarquez@aamc.org.