National Rural Health Association

October 31, 2025

The Honorable Bill Cassidy
Chairman
Senate Health, Education, Labor, and Pensions Committee
Washington, D.C. 20515

The Honorable Bernie Sanders
Ranking Member
Senate Health, Education, Labor, and Pensions Committee
Washington, D.C. 20515

RE: The 340B Program: Examining Its Growth and Impact on Patients

Dear Chairman Cassidy and Ranking Member Sanders,

The National Rural Health Association (NRHA) thanks the Senate Health, Education, Labor, and Pensions (HELP) Committee for its attention to the 340B Drug Pricing (340B) Program in its recent hearing, "The 340B Program: Examining Its Growth and Impact on Patients." As discussed throughout the hearing, 340B is an invaluable program for rural hospitals and community health centers that rely upon savings to serve their patients through discounted or free medications to sustaining otherwise untenable service lines.

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, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA appreciated the Committee's attention to rural covered entities during the hearing and acknowledgment that these covered entities' participation in the program aligns with the intent to stretch scarce federal resources further. Rural hospitals and clinics operate on thin margins and 340B savings help them keep needed services local for rural patients. Approximately 46% of rural hospitals are operating with negative margins and therefore are vulnerable to closure.[1] Specific services, such as obstetrics and chemotherapy, continue to vanish in rural areas at an alarming rate.[2] When a rural hospital or service line closes, the impact can be devastating for a community. Given challenges that rural covered entities are likely to face in the coming years including cuts to the Medicaid program, 340B will become an even more crucial lifeline for both providers and patients.

NRHA offers its reform policy principles to guide discussions as the Committee considers potential reforms discussed during the hearing, such as transparency and the definition of a 340B patient.

Protect rural access. NRHA believes that preserving the original intent of the 340B Program – to stretch scarce federal resources – must be the core of any legislative proposal to ensure rural covered entities' continued participation. Providers are best situated to determine how 340B savings can be used to benefit their rural communities without broad legislative or regulatory mandates.

[1] Michael Topchik, et al., *2025 rural health state of the state*, Chartis Center for Rural Health (2025), 2, https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf.
[2] *Id.* at 5-6 (Between 2014 and 2023, 424 rural hospitals stopped providing chemotherapy services. This represents 21% of all rural hospitals offering chemotherapy. Additionally, 293 rural hospitals stopped offering OB services between 2011 and 2023).

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Contract pharmacies. NRHA does not support any limitations on the number or location of contract pharmacies that rural covered entities can work with. Echoing Senator Murkowski's comments during the hearing, we assert that restricting the number of contract pharmacies that a covered entity may use disproportionately constrains access for rural patients. Many rural covered entities are too small to support an in-house pharmacy and must rely upon outside pharmacies. Given the geographic spread of rural areas, patients of rural covered entities travel farther, and thus multiple contract pharmacies should be available to ensure rural access.

Orphan drugs. NRHA supports relief from the orphan drug exclusion for critical access hospitals, sole community hospitals, and rural referral centers. This exclusion only applies to rural hospitals covered entities and thus comes at an unfair cost for rural patients that require these lifesaving treatments such as oncology treatment, access to which is decreasing in many rural areas.

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

Oversight. As witnesses discussed during the hearing, Health Resources and Services Administration (HRSA) lacks the resources and has limited ability to meaningfully regulate the 340B program. NRHA supports granting HRSA clear oversight and regulatory authority to protect the integrity of the 340B Program.

Dispensing fees. NRHA believes that 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.

Child site arrangements. 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, in surrounding areas, thus requiring these locations to serve as access points for rural 340B patients.

Patient definition. NRHA supports HRSA's 1996 definition of a patient with the addition of allowing telehealth services to count as patient visits for covered entities in rural areas. Current HRSA guidance on defining 340B patients must be codified in the statute to provide clarity. Additionally, the statute should make clear that covered entities are able to claim prescriptions from a referring provider if the covered entity retains the ultimate responsibility for the patient's care.

Reporting requirements. NRHA encourages limits on program reporting and supports data collection only insofar as it is using data that entities are already reporting in another federal program to demonstrate community benefit. NRHA agrees with Senator Baldwin's point raised during the hearing that increased transparency in 340B may be needed but should not place undue administrative burden on covered entities. Rural covered entities do not have the capacity to comply with additional unfunded mandates for reporting on 340B savings.

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NRHA stands by the principles outlined above as integral to any 340B reforms pursued by Congress. We look forward to working with the Committee to preserve and strengthen rural access to the 340B program. To discuss 340B further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Sincerely,

Alan Morgan
Chief Executive Officer
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