AIMPA

American Independent Medical Practice Association®

October 22, 2025

The Honorable Bill Cassidy
Chairman
U.S. Senate Committee on Health, Education, Labor, and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Bernie Sanders
Ranking Member
U.S. Senate Committee on Health, Education, Labor, and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Cassidy, Ranking Member Sanders, and Members of the Committee:

On behalf of the American Independent Medical Practice Association ("AIMPA"), thank you for convening Thursday's hearing on the 340B Program. We appreciate the Senate Health, Education, Labor, and Pensions Committee's willingness to examine the structure, trajectory, and downstream consequences of 340B at a moment when the program has expanded far beyond its original intent and is materially reshaping the delivery system for physician services in the United States.

AIMPA is the country's first national, multi-specialty advocacy organization devoted exclusively to the interests of physicians caring for patients in independent medical practices. AIMPA represents more than 600 independent medical practices in 46 states. These practices include over 12,000 physicians who provide high-quality, affordable health care for approximately 25 million patients each year.

The physicians we represent compete against hospital-affiliated physicians for patients on the basis of quality and cost. Research shows that independent physicians routinely deliver care in lower-cost settings at much higher rates than hospital-affiliated physicians. AIMPA therefore has a direct stake in how federal

policy -- including 340B -- shapes competitive dynamics in local markets.

We respectfully summarize our core concerns here for the Committee's consideration before the hearing.

In its current form, the 340B program gives hospitals a substantial, non-market competitive edge over independent physician practices. The ability to acquire deeply discounted drugs and bill them to Medicare and commercial insurers at full price grants hospitals a significant revenue stream and further incentivizes consolidation into the hospital setting. In 2013, 340B generated about $3.5 billion in profits for hospitals and PBMs; by 2023, that figured soared to $64.4 billion.

That additional revenue does not have to be -- and often is not -- used to subsidize care for low-income or underserved patients. Instead, it is routinely used to finance strategic expansion, particularly the acquisition of independent physician practices and the conversion of those practices into outpatient departments or "child sites" of 340B entities.

The resulting consolidation is not an incidental side effect -- it is intrinsic to the economics of 340B. The more independent practices a hospital system acquires, the more sites it can deem 340B-eligible -- and the more drug revenue it can harvest to expand further.

In the end, hospitals acquire more negotiating clout with payers, people have fewer choices in where they can seek care, and Medicare, private insurers, and patients must shoulder higher costs.

The cycle is self-reinforcing, and the effects are well-documented. A New York Times investigation found that Bon Secours Mercy Health in Virginia used 340B profits from its community hospital to open new ambulatory clinics in affluent suburban areas -- facilities that, on paper, are treated as subsidiaries of a safety-net entity solely to capture 340B revenue -- even as the system closed the intensive care unit and reduced services at the community hospital serving a disadvantaged population.

Bon Secours Mercy Health's actions are emblematic of a programmatic design that permits and even rewards geographic arbitrage and mission drift.

Peer-reviewed research shows that 340B does not function as a reliable safety-net program. A 2021 study in the American Journal of Managed Care found that hospitals entering the 340B program did not increase their provision of uncompensated care more than non-340B hospitals. In other words, participation in the program does not correlate with greater safety-net behavior -- even though the program is frequently defended on that premise.

The 340B program in its current form does not merely operate counter to congressional intent -- it actively re-orders market structure in ways that reduce competition and increase healthcare spending. Every incremental hospital acquisition financed by 340B makes it more difficult for independent practices to remain viable, even when they deliver care at lower cost and equal or higher quality than hospital-affiliated practices.

We are grateful that the Committee is examining these issues in a public hearing. Oversight of this program is overdue and critically important. We urge the Committee to consider reforms that realign 340B with its intended purpose, prevent further distortion of local markets, protect Medicare beneficiaries, and preserve the viability of independent physician practice.

Thank you again for your leadership and for convening this hearing. AIMPA would welcome the opportunity to serve as a resource to Members and staff as you evaluate potential policy solutions. Please do not hesitate to reach out to AIMPA President and Board Chair Dr. David Eagle (david.eagle@aimpa.us; 704-453-9632) if AIMPA can be of further assistance.

Sincerely,

Dr. David Eagle
AIMPA President and Board Chair

Dr. Kartik Giri
AIMPA Chair, Federal Health Policy