PR

PATIENTS RISING

FALL 2025

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THE 340B HOSPITAL HUSTLE

NONPROFIT HOSPITALS TURN FEDERAL DRUG DISCOUNTS INTO PROFIT PIPELINES WHILE SUING THE PATIENTS THEY'RE SUPPOSED TO HELP

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FROM THE FOUNDER

The 340B Program Was Built to Protect Patients, But Who's Protecting Them Now?

When Congress created the 340B Drug Pricing Program in 1992, the idea was clear and, frankly, admirable. Drug companies would be required to give certain hospitals and clinics deep discounts on outpatient medicines. In return, those institutions would stretch their savings to provide more care and more services for the people who need them most. It was meant to be a safeguard for low-income and uninsured patients in a health system that too often leaves them behind.

That is what the law says. But the reality I hear from patients tells a very different story.

Hospitals can buy drugs at discounts of 20 to 50 percent, but nothing in the law requires them to pass those savings to patients. And there is almost no accountability. Less than 2 percent of hospitals are audited each year. That means nearly every hospital in the program is allowed to operate without real oversight.

And what do we see? We see hospitals using 340B revenue to finance expansion into wealthy suburbs. We see generous executive paychecks. We see patients sued for medical debt by the very hospitals that were supposed to be their safety net. For years, lawmakers have been warned about these abuses. In 2018, the House Energy and Commerce Committee issued a report that found major weaknesses, including limited regulatory authority for HRSA, the agency that oversees the the program, and no requirement for hospitals to report how they use 340B savings.

There is also evidence that some hospitals have figured out how to game the system. Research has shown that 340B hospitals often prescribe more medicine, and more expensive medicine, to patients who qualify for the program. Outpatient oncology care is often twice as costly at 340B hospitals compared to those that do not participate. This is not the spirit of the law. It is the exploitation of a loophole.

And let's not forget the patients. A 2017 report by the Community Oncology Alliance documented stories of care denial for the uninsured, Medicaid patients turned away, and hospitals that clearly preferred insured patients over the indigent ones who should be at the heart of this program. Those stories are not the exceptions. They are the red flags.

Meanwhile, policy battles rage over reimbursement. CMS tried to cut payment rates for 340B-acquired drugs in 2018 and 2019, but a court ruled the agency had gone too far. That fight continues, with reimbursement numbers being shuffled and debated in Washington, while patients outside the Beltway are left with higher out-of-pocket costs and fewer choices.

Here's what I believe: the 340B program has done good for some communities, but it has also created perverse incentives and allowed hospitals to profit without showing the public how those profits are being used. If hospitals are saving billions of dollars a year, they should be required to prove that those dollars are being used to help patients. Reporting requirements are not an attack on safety-net hospitals. They are common sense.

Patients deserve to know whether the system that was built in their name is working for them, or whether it has been captured by the institutions that were supposed to serve them. Right now, too often, it looks like the latter. And until there is transparency, patients will continue to pay the price.

Yours in Advocacy,

Terry Wilcox

Terry Wilcox
Co-Founder and Chief Mission Officer
Patients Rising

CHARITY TRAP

HOSPITALS PROFIT FROM A PROGRAM FOR THE POOR WHILE PATIENTS DROWN IN DEBT

More than thirty years ago, Congress built the 340B Drug Pricing Program as a promise to the poor and uninsured. The premise was straightforward. Hospitals that cared for the most vulnerable would be able to buy outpatient drugs at steep discounts, then use the savings to widen access and lower costs. It was conceived as a lifeline in a system where affordability is too often out of reach.

Yet over time the lifeline has been transformed into something else entirely. What began as a measure of mercy has become one of the most profitable and least accountable spaces in American healthcare. Hospitals purchase drugs for a fraction of their listed price, sometimes 20 to 50 percent less, then charge insurers or patients the full commercial rate. The gap, sometimes many times the cost, is retained as profit. Nationally the program now feeds nearly $65 billion into hospital and pharmacy revenue streams every year, a sum that represents not charity but commerce.

Currently, there is no requirement that hospitals show how they use the money, no mandate that the savings find their way to the bedside. Federal audits are rare, sweeping past 99.7 percent of providers without scrutiny. In that void, hospitals have redirected the gains toward construction, suburban expansion, and executive salaries.

And some, like Mary Washington Healthcare, have gone further still, pressing patients into court for unpaid bills even as they profit from drug arbitrage. What was designed as a safeguard for patients has instead become a system that too often prioritizes revenue over relief.

Michael McDermott, the former CEO of Mary Washington Healthcare

In Virginia the consequences are visible in the bankruptcy courts.Records show families overwhelmed by six-figure debts owed to hospitals that should have been their safety net. One patient, whom we will call Janet Scott*, carried medical debt of more than $380,000, nearly all of it tied to Mary Washington Hospital. Another, Richard White*, owed close to $200,000 to the same institution. Both were left with court summonses and the growing weight of financial collapse.

Arbitrage in Action

The mechanics behind these debts are straightforward. A hospital acquires a cancer drug at a discounted 340B price of $1,000 while the same hospital bills an insurer $6,000 for that drug and collects the difference. If a patient is uninsured, the bill for the full amount can land directly in their mailbox. The margin, sometimes hundreds of percent above cost, is retained by the hospital. For patients like Scott and White, the impact was not the easing of medical costs, but rather debts that continued to climb. This practice has become part of a larger financial picture that raises questions about how nonprofits use their advantages.

Nonprofit in Name

Mary Washington Healthcare's IRS filings tell a story at odds with its image as a community institution. In 2021 the hospital reported $147.9 million in annual revenue and $7.95 million in net profit, and executive pay was generous. Michael McDermott, the president and chief executive from January 2015 through January 2025, received more than $2.1 million in total compensation, with numerous other executives earning in the high six figures.

The same filing disclosed a related-party transaction. Dr. Brian McDermott, the chief executive's brother, was paid $119,119 for consulting described only as collaboration with orthopedic specialists to improve quality, efficiency and cost-effectiveness of care. The disclosure provided no information on deliverables or measurable outcomes. These details add to a pattern of revenue strategies that extend beyond patient care.

The Double Game

Hospitals like Mary Washington have mastered a cycle of accumulation.

They draw profit from 340B drug arbitrage, shield themselves with the privileges of tax exemption, and then turn to the courts to demand payment from patients. It is a system that blends public benefit status with aggressive private collection.

Bankruptcy filings in Virginia show how common this has become. Beyond Scott and White, patients such as Rebecca Miller*, who owed $370,000, and James Carter*, who owed $282,000, were pulled into bankruptcy by liabilities to 340B hospitals. The pattern is consistent across the state and helps explain how hospitals expand their financial reach even while patients struggle.

Contract Pharmacies in Wealthy Zip Codes

The reach of 340B extends beyond the hospital campus. Mary Washington and other 340B institutions have partnered with national pharmacy chains to dispense discounted drugs. But studies show these contract pharmacies are disproportionately located in affluent neighborhoods rather than in communities where vulnerable patients live. Patients rarely receive meaningful savings at the counter, and most pay full retail price for medications that hospitals purchased at steep discounts. These arrangements further highlight how program dollars can flow away from those most in need.

A Mission Subverted

Mary Washington Healthcare states in its tax filings that its mission is "improving the health of the people in the communities we serve." For patients like Scott and White, that promise has not aligned with their lived experience of debt and collection actions.

The 340B program was envisioned as a support for the poor and uninsured, yet it has increasingly become a financial engine for hospitals that already enjoy tax benefits. As policymakers debate reforms, the stories emerging from bankruptcy courts in Virginia underscore why oversight and transparency matter.

Continued on Page 9.

***Name has been changed for privacy.**

Michael McDermott's home at 213 Caroline Street, which sold for $2.95 million on July 10 under the name 213 Caroline LLC, is nothing short of extravagant. The 1764 Georgian estate spans five city lots along the Rappahannock River, complete with a paneled parlor once fit for Revolutionary War leaders, a guest house and even a modern golf simulator room.

Photo credit: Zillow.com

Dr. Brian McDermott, brother of Mary Washington Healthcare's Chief Executive Officer Michael McDermott, was paid $119,119 in 2021 for consulting described only as collaboration with orthopedic specialists to improve quality, efficiency and cost-effectiveness of care. Photos taken from his public Facebook page show him taking multiple vacations from Hawaii to Dubai.

FINANCIAL SUMMARY

Mary Washington Hospital 2021-2023

Metric	2021	2022	2023
Gross Receipts	$203.9M (parent only)	$892.2M (group return)	$231.2M (parent only)
Total Revenue	$172.0M	$863.4M	$135.0M
Total Expenses	$131.1M	$838.7M	$144.4M
Net Income (Rev – Exp)	+$41.0M	–$3.1M (loss)	–$6.3M (loss)
Total Assets (End of Year)	$690.2M	$593.7M	$655.2M
Total Liabilities (End of Year)	$169.8M	$353.4M	$132.1M
Net Assets (End of Year)	$520.4M	$212.0M	$523.1M

Mary Washington Healthcare's finances look very different depending on which type of tax return they file. In some years, the organization files what is known as a parent-only return. In others, it files a group return.

- **Parent-only return:** This shows only the finances of the management company at the top of the system. It includes administrative costs, management fees and support services, but it leaves out the full operating revenue and expenses of the hospitals and clinics themselves.

- **Group return:** This combines everything — the parent company, the hospitals, the outpatient centers, the physician groups and all their revenues and costs. It's a fuller picture of how much money the entire health system takes in and spends.

Both methods are legal, and the IRS allows nonprofits to choose how they file. Hospitals often switch between the two depending on what narrative they want to emphasize in a given year.

In practice, it is a way for nonprofit hospitals to shape the optics. They can present one picture of their finances while still enjoying the benefits of tax exemptions and federal programs like 340B. For patients being sued into bankruptcy, it means the hospital's real financial muscle is kept out of sight, hidden in the choice of which numbers get reported.

EXECUTIVE COMPENSATION TRENDS

Mary Washington Hospital 2021-2023

Executive	2021 Total Comp	2022 Total Comp	2023 Total Comp
Michael P. McDermott, MD, MBA – President & CEO	~$2.18M (plus deferred)	~$1.8M	~$1.94M
Christopher Newman, MD – COO/CMO (later EVP)	~$922K	~$969K	~$1.0M+
Sean Barden, EVP & CFO	~$860K	~$829K	~$918K
Eric Fletcher (CSO)	~$750K	~$566K	~$544K
Travis Turner (CPHO)	~$735K	~$655K	~$672K
Eileen Dohmann (CNO, thru 2023)	~$641K	~$492K	~$494K (thru May '23, later successor)

What stands out in Mary Washington's filings is not just how much executives are paid, but how those salaries appear depending on which set of books the hospital chooses to show.

In parent-only filings (2021 and 2023), the organization reports roughly $140 million in revenue. Against that smaller base, a CEO salary of nearly $2 million and other executives earning $600,000 to $900,000 consume a strikingly large share of the resources. To the average person, it looks like leadership pay towers over the size of the operation.

In group filings (2022), the full hospital system is included, with more than $800 million in patient revenue flowing through. The very same executive salaries are still there — $1.8 million for the CEO, nearly $1 million for physician leaders, high six figures for others — but they appear less outsized when measured against the larger pool of hospital revenue.

The pay does not actually change. What changes is the denominator. Parent-only reporting makes the salaries look extravagant, while group reporting buries them in a mountain of patient service revenue. Either way, the compensation remains steady at the top, even in years when the system posted losses and patients were dragged into court over unpaid bills.

For a nonprofit hospital claiming to serve its community, the choice of reporting method shapes not just the numbers, but the optics , and in doing so, it obscures the growing gap between executive security and patient vulnerability.

Calls for Reform

Lawmakers and watchdogs have begun to press for change. Proposals include requiring hospitals to show that 340B savings benefit patients, mandating public reporting, and expanding federal audits. Others call for stricter definitions of eligible hospitals and pharmacies to ensure that benefits flow to underserved communities rather than affluent ones.

Change has been slow, in part because hospitals and their lobbyists fiercely defend the program. They argue that 340B revenue supports critical services and warn that reforms could undermine care. For patients already overwhelmed by debt those arguments ring hollow.

The Human Cost

The numbers are staggering. Billions in profit, millions in executive compensation, thousands of lawsuits. But the true cost of 340B misuse is measured in the lives of patients like Scott, who lost her financial footing, and White, who faced mounting bills he could never hope to pay. Their experiences echo a national crisis, one in which hospitals wear the mask of charity while operating as profit machines.

Until transparency and accountability are enforced, the safety net will continue to unravel. And patients who believed they were in the care of a nonprofit hospital will keep discovering, too late, that the institution meant to heal them has also become their creditor.

340B AT A GLANCE

Created: 1992, by Congress

Goal: Help hospitals that serve low-**i**ncome and uninsured patients by letting them buy drugs at steep discounts

Discounts: Typically 20–50% off outpatient medicines

Expectation: Hospitals use savings to expand care, provide more charity services, and lower costs

Reality: Hospitals bill insurers and patients at full commercial rates, pocketing the difference

Oversight: Fewer than 2% of providers audited each year

Result: Nearly $65 billion in annual hospital revenue, with little proof that patients see the benefit

PATIENTS RISING

Empowering every patient in America to advocate for reforms placing them, alongside their doctors, in control of their healthcare choices.

www.patientsrising.org