PR

PATIENTS RISING

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CHARITY IS INVOKED IN NAME BUT RARELY IN PRACTICE

THE 340B HOSPTIAL HUSTLE

NONPROFIT HOSPITALS TURN FEDERAL DRUG DISCOUNTS INTO PROFIT PIPELINES

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

A PROGRAM FOR THE POOR, A PAYDAY FOR HOSPITALS

Billing dispute shows 340B savings rarely reach patients

When Jennifer Garzia checked her hospital bill after delivering her third child by cesarean section at Lankenau Medical Center in suburban Philadelphia, one detail stopped her cold.

The procedure had been billed twice.

Garzia, a seasoned patient advocate who knew her way around a claim form, did what most patients are told to do. She called her insurance company, her obstetrician and the hospital's billing office. Both her insurer and physician agreed the charge was an error. The hospital did not.

“Who are you going to believe?” a representative told her. “This is what we do for a living.”

The dispute was eventually resolved after months of calls and a three-way conference with her insurer, though the hospital never explained or apologized for the duplicate charge. To Garzia, the experience was less about a clerical mistake and more about the system’s quiet mastery of imbalance, one that often leaves patients without answers while hospitals thrive on programs meant to serve those in need.

At the center of that imbalance sits a little-known federal initiative called the 340B Drug Pricing Program. Established by Congress in 1992, it was designed to help safety-net hospitals stretch their resources and improve care for uninsured and low-income patients. Under the law, drug manufacturers must sell certain outpatient medications to qualifying hospitals at steep discounts, sometimes as much as 50 percent below market price. The expectation was that hospitals would pass along the savings to patients who needed financial relief.

In practice, that rarely happens. Hospitals buy drugs at the reduced rate and bill insurers or patients at full price, pocketing the difference as unrestricted revenue. Oversight is minimal.

A 2018 report by the Government Accountability Office found that most participating hospitals failed to extend those discounts to patients. Earlier this year, an investigation led by Senator Bill Cassidy of Louisiana revealed widespread misuse of the program, documenting cases in which hospitals reaped millions from the price gap with little evidence that patients benefited.

“This isn’t an oversight,” Garzia said in an interview. “It’s the business model.”

The data bear that out. For every ten dollars collected through the 340B program by the most profitable hospitals, only about one dollar is spent on charity care, according to federal estimates. Nearly seventy percent of hospitals that qualify for the program because they serve a disproportionate share of low-income patients actually provide less uncompensated care than facilities that do not participate at all.

Hospitals have become adept at defending the arrangement, citing the high costs of uncompensated care and the volatility of drug pricing. Yet the financial gains are undeniable. Main Line Health, the nonprofit network that operates Lankenau, reported millions in executive compensation in its most recent filings.

Its former chief executive earned more than three million dollars annually, while six senior leaders collectively earned nearly eight million.

Meanwhile, patients like Garzia confront complex billing systems that often resist correction. “Hospitals are entrusted with taxpayer-funded discounts,” she said. “If they can’t show where the money goes, maybe they shouldn’t have access to it.”

The consequences of that imbalance extend far beyond accounting disputes. Since 2008, nearly four hundred community oncology clinics have closed nationwide, squeezed by hospital systems able to purchase chemotherapy drugs at deep discounts unavailable to independent providers. More than half of the pharmacies operating under 340B contracts are located in affluent neighborhoods, not the underserved communities the program was intended to reach.

The result is a paradox of access: care grows less local, less personal and more expensive, while nonprofit hospitals expand their footprints and their margins.

Garzia’s own billing dispute ended quietly — with a keystroke and a vanished charge — but it highlighted what she sees as the broader erosion of trust between patients and the institutions meant to care for them.

Reform, she argues, starts with definition and disclosure. Congress should establish a uniform definition of who qualifies as a “340B patient,” enforce consistent standards for participation and require public reporting of profits and patient outcomes. “These are not trade secrets,” she said. “They’re accountability measures.”

Now the Director of Events at the advocacy organization Patients Rising, Garzia channels her experience into her work amplifying patient voices on Capitol Hill. “Hospitals say they’re helping the poor,” she said. “Then they turn around and bill them full price.”

The 340B program was built on the promise that savings would strengthen care for those who need it most. Three decades later, that promise has blurred into profit. The question now is whether Congress will restore the law’s intent—or continue to let hospitals define it for themselves.

THE PRICE OF "NONPROFIT" CARE

Ochsner Health earns millions from 340B

For most of her adult life, Vickie Wilkerson has made regular trips across Louisiana to visit her doctors at Ochsner Health. The 57-year-old patient advocate has lived with psoriasis and psoriatic arthritis for more than two decades and has long depended on Ochsner's care.

"Ochsner's doctors and nurses have always cared deeply for their patients," she said. "It's a shame their executives don't share that same commitment." Ochsner is Louisiana's largest health system, with 47 hospitals and more than 370 clinics across the Gulf South.

The nonprofit reported $7.7 billion in revenue and $157 million in profit last year. Much of that income, Wilkerson said, comes from the 340B Drug Pricing Program, a federal initiative meant to make medicine more affordable for low-income and rural patients.

Louisiana hospitals have signed more than 1,100 pharmacy contracts, some out-of-state. A recent study found that most 340B pharmacies meant to serve the poor are instead located in wealthy neighborhoods. Less than two percent of 340B hospital revenues in Louisiana go to charity care, among the lowest rates in the nation.

At Ochsner, it is less than one percent. According to federal filings, only 0.88 percent of operating expenses go toward financial assistance. "If 340B savings aren't reaching patients, where are they going?" Wilkerson asked.

Tax records show executives receiving multimillion-dollar compensation packages, first-class travel, and discretionary spending accounts. In 2023, Ochsner paid CEO Peter November $5 million—104 times Shreveport's median household income. Thirty-four other employees earned more than $47 million combined.

"This is a nonprofit organization exempt from federal income tax," Wilkerson said. "That should mean something."

Across the country, the 340B program has become a $66 billion revenue source for hospitals and pharmacies. Earlier this year, Sen. Bill Cassidy of Louisiana released a report detailing widespread abuse of the program, urging that reform is needed.

Wilkerson agrees. "Congress created 340B to help vulnerable patients. Now it needs to fix what it's become."

ALIVE, BUT PAYING THE PRICE

Near-death experience exposed how the 340B fails patients

When Rick Dowlearn opened his eyes in a hospital bed last spring, he learned two things: he was alive and for a brief moment in time, his name was Almond Rectangle.

The alias wasn't a clerical mistake. When Dowlearn arrived at West Virginia University Berkeley Medical Center, he was unconscious, without identification and fighting for his life. His phone and wallet were locked in his car and no one knew who he was. The hospital's electronic records system automatically assigned a random name to the unidentified patient with a failing heartbeat. Almond Rectangle was the one it chose. It stayed on his chart until he was stable enough to say who he really was.

Dowlearn, a 52-year-old television producer from Maryland, had suffered a cardiac arrest while driving less than 40 miles from his home in Brunswick. Paramedics revived him with CPR and defibrillation, then rushed him to WVU Berkeley. Doctors implanted a defibrillator and pacemaker to keep his heart rhythm steady. One month later, surgeons at Johns Hopkins in Bethesda performed a quintuple coronary bypass using tissue from his leg to reroute blood flow around blocked arteries.

By then, Dowlearn was broke. "I'd had a great career in television," he said, "but the jobs were drying up, production work was shrinking and so was my bank account."

Once he regained his strength, he began asking questions about the care that had kept him alive and what it cost. "I knew it had to be expensive," he said, "but what I didn't know was how the billing actually worked or who was supposed to help."

That search led him to the 340B Drug Pricing Program, a federal initiative Congress created in 1992 to help safety-net hospitals stretch limited resources and assist low-income or uninsured patients with the cost of medications. Under the law, drug manufacturers must sell certain outpatient drugs to qualifying hospitals at steep discounts, sometimes half the market price. The idea was simple: hospitals would pass those savings to patients who needed them most.

Dowlearn assumed that, given his situation, he would have qualified for that kind of relief. WVU Berkeley participates in the 340B program and as a patient in financial distress, he seemed like the type of person it was meant to help. But when he called the hospital to ask, no one could tell him if he had benefited from it. "Most of the people I spoke to had no idea what 340B even was," he said.

The deeper he looked, the clearer the pattern became. The

340B program has quietly shifted from a safety-net measure to a lucrative revenue stream for hospitals.

Rather than passing discounts to patients, hospitals often purchase drugs at reduced rates and bill insurers or patients at full price, keeping the difference.

“The 340B program has become a ‘buy low, sell high’ scheme funded by taxpayers,” Dowlearn said. “Hospitals purchase medications at steep discounts, then turn around and charge patients and insurers full price. The profits are jaw-dropping and bold.”

He pointed to examples that illustrate the imbalance. One New Mexico hospital bought a cancer drug for $2,700 through 340B then billed an insurer $22,700, collecting a $20,000 profit on a single prescription.

Federal data show how far the program has drifted from its intent. Sixty-three percent of hospitals receiving 340B discounts provide less charity care than the national average. More than one-third spend under one percent of their budgets on charity care. Hospitals that do not participate often give more.

Instead of using 340B savings to reduce costs for patients, many hospitals funnel the proceeds into executive bonuses, new construction projects and expansion into wealthier neighborhoods. “Smaller clinics are closing and that means less choice, less convenience and higher costs for patients,” Dowlearn said.

He paid what he could of his hospital bills but some remain in collections. “I was the kind of patient this program was designed to help,” he said. “But if any of that money ever reached me, I’ll never know. The savings stop at the hospital door to the left of the new fountain while patients like me carry the cost long after discharge.”

Dowlearn believes the first step toward fixing the program is to define who qualifies as a “340B patient.” Without a clear statutory definition, hospitals can interpret eligibility however they choose. “If there’s a patient definition, hospitals can’t play games,” he said. “In my case, I would have had a program to apply to or appeal when I got those sky-high bills.”

He makes clear that his frustration isn’t directed at the doctors or nurses who treated him. “The staff at WVU Berkeley saved my life,” he said. “For that, I’m grateful beyond words.” What troubles him is that the hospital never informed him of a federal program meant to help patients in his position.

For Dowlearn, the 340B program remains what it was in those first hours of confusion, an unknown name on a screen, detached from the patient it was meant to serve.
“Instead, for me,” he said, “and for many others, the 340B Program remains as unknown as an Almond Rectangle.”

PATIENTS RISING

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

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