

ISSUE BRIEF

Profiting from 340B

A Review of Charity Care and Financial Performance at 340B Hospitals

Wayne Winegarden

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Pacific Research Institute
680 E. Colorado Blvd. #180
Pasadena, CA 91101
Tel: 415-989-0833
Fax: 415-989-2411
www.pacificresearch.org

Download copies of this study at www.pacificresearch.org.

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Executive Summary

The purpose of the 340B drug discount program is to help vulnerable patients receive their required medications. Yet, despite the exceptional growth in total 340B sales, there is scant evidence that 340B hospitals are increasing their outreach to vulnerable populations.

In its examination of the program, the Government Accountability Office (GAO) found that the program's oversight does "not provide reasonable assurance that participating nongovernmental hospitals meet eligibility requirements."¹ Not surprisingly, the evidence illustrates that 340B hospitals tend to provide less charity care (the *raison d'être* of the program) while still providing these institutions with a very profitable revenue source.

To provide additional perspective on these issues, this analysis examines the hospital data from the Centers for Medicare and Medicaid Services (CMS) Healthcare Provider Cost Reporting Information System (HCRIS) and the financial data reported to the IRS (from the hospitals' 990 forms) for a sample of 340B hospitals.

The HCRIS data provides operational and financial information on hospitals that include each hospital's cost of charity care.² Benchmarking each hospital's net income and charity care spending to net patient revenues, the hospitals in the CMS database devoted 2.03 percent of their net patient revenues toward charitable care in 2017. However, leveraging the list of the current 340B covered entities maintained by the Health Resources & Services Administration, the Office of Pharmacy Affairs 340B OPAIS,³ charitable spending as a share of net patient revenues by 340B hospitals was a smaller 1.66 percent. This data provides further support that 340B hospitals are not fulfilling the program's mission.

While not providing more charitable care, 340B hospitals are more profitable than the average hospital. Evaluating each hospital's net income relative to net revenue demonstrates that the profitability (or excess of revenues over costs for non-profit hospitals) of 340B hospitals was 37 percent larger (6.25 percent compared to 4.55 percent) at 340B hospitals compared to the average of all hospitals.

Since the 340B program has been growing so quickly, it is also interesting to examine the growth of the profitability of these institutions. To provide information on this question, the IRS form 990s from a sample of 25 large hospitals across eight demographically and geographically diverse states were examined.

The sample of 340B hospitals provided less relative charity care (a median value of 0.66 percent) while experiencing stronger profitability (a median value of 8.0 percent for 2019) relative to the average hospital as well as the average 340B hospital. The financial performance of these hospitals was also significantly better than relevant industry benchmarks.

“ While not providing more charitable care, 340B hospitals are more profitable than the average hospital.

For instance, while the average annual growth in expenditures at hospitals was 4.4 percent between 2010 and 2019 according to the CMS National Health Expenditure data, the median growth in revenues at the sample of 340B hospitals was 5.1 percent annually.

The growth premium for profits was even starker. Profits at the sample of 340B hospitals grew 9.1 percent annually over this period compared to profitability growth of 2.5 percent annually at hospitals and nursing care facilities according to data from the National Income and Product Accounts (NIPA) maintained by the Bureau of Economic Analysis (BEA).

As a final area of concern, the sample of 340B hospitals maintained 54 contract pharmacies, compared to an average of 20 contract pharmacies for the average 340B hospital. The growth in contract pharmacies has been troubling because it is worsening the problems of diverting 340B discounted medicines to non 340B-eligible patients, enabling institutions to receive duplicate discounts from both Medicaid and the 340B program when such duplication is prohibited, and not offering the 340B discounted price to uninsured patients.

These results provide further support that while the goal of helping vulnerable populations is laudable, the 340B program is failing to serve this purpose. Instead, the program has become an unwarranted subsidy for many large hospitals. And, while there are many policy disincentives that are unjustifiably harming hospitals' financial viability, the purpose of 340B is not to compensate for these costs. It is time, consequently, to reform 340B.

Introduction

In our 2017 publication, “Addressing the Problems of Abuse in the 340B Drug Pricing Program” we noted that 340B’s purpose is,

to ensure vulnerable patient populations have access to their medicines by forcing drug manufacturers to sell low-priced medicines to covered entities, in the anticipation that these lower prices will, ultimately, help vulnerable populations receive more affordable care. By attempting to help vulnerable patient populations in such an overly complicated manner, the 340B program creates inefficiencies throughout the program as well as throughout the broader healthcare market.

These inefficiencies and distortions include: the abuse of the 340B program by covered entities; the incentive of covered entities to prescribe more expensive medicines; a shifting of drug costs onto non 340B patients that raises the prices these patients pay for medicines; and an unwarranted consolidation of medical practices. Due to these inefficiencies, the 340B program worsens the quality of the overall health care system.⁴

Considering these problems, we recommended reforms to rein in the program including limiting the program to healthcare providers and hospital systems serving the intended low-income populations (e.g., disproportionate share hospitals and clinics) and ensuring that these same patients directly benefited from the financial discounts when receiving their medications. Four years later, these problems remain unaddressed.

340B: Growth and Misuse

The 340B program is named for section 340B of the Veterans Health Care Act of 1992 and is administered by the Health Resources and Services Administration (HRSA). It was designed to provide safety-net facilities discounted drugs to improve vulnerable populations’ access to medicines. As the Government Accountability Office (GAO) notes,

to be eligible for the 340B Program, hospitals must meet certain requirements intended to ensure that they perform a government function to provide care to low-income, medically underserved individuals. Hospitals must be (1) owned or operated by a unit of state or local government; (2) nonprofit corporations that have been formally granted state or local governmental powers; or (3) private, nonprofit hospitals that have contracts with state or local governments to provide health care services to low-income individuals who are not eligible for Medicaid or Medicare.⁵

Under the program, participating pharmaceutical manufacturers must provide qualifying clinics and hospitals (also known as covered entities) discounts up to 50 percent or more off the costs for outpatient drugs, otherwise their drugs will not be covered by Medicaid. Improving vulnerable populations’ access to medicines is clearly important, but the evidence raises concerns that the 340B program is failing to meet this goal.

The size and scope of the program have clearly exploded. As Drug Channels noted,

discounted 340B purchases were at least \$29.9 billion in 2019. That figure is an astonishing 23% higher than its 2018 counterpart.

Since 2014, purchases under the 340B program have tripled. Over the same period, manufacturers' net drug revenues have grown at an average rate that's below 5%. Consequently, the 340B program has grown to account for more than 8% of the total U.S. drug market and about 16% of the total rebates and discounts that manufacturers provide.

What's more, the 340B program is now almost as large as the Medicaid program's outpatient drug sales. However, 340B lacks Medicaid's regulatory infrastructure and controls. Medicaid rebates directly and transparently lower drug costs for the government, while 340B discounts disappear into providers' financial statements.⁶

Simply because the sales volume of 340B drugs is experiencing extraordinary growth does not mean that the program is achieving its purpose, and there is mounting evidence it is not.

As the GAO has noted, "HRSA's processes do not provide reasonable assurance that participating nongovernmental hospitals meet eligibility requirements."⁷ Consistent with the GAO's concerns, there is growing evidence that 340B hospitals are devoting a below average share of expenditures toward charity care relative to the share devoted by the average hospital.

According to a study by AIR340B, "for all hospitals (340B and non-340B), charity care costs as a percent of all patient costs ranged from 3.3 percent to 2.2 percent between 2011 and 2017, respectively."⁸ Relative to this industry average, "nearly two-thirds of all 340B hospitals provide a below average level of charity care. Despite the growth of 340B from 2012 through 2017, this number has remained relatively steady."⁹

While the amount of charity care provided by 340B hospitals is below average, their profitability appears to be improving. A study by Masia (2021) estimated the profitability of 340B drug sales based on therapeutic area sales data from HRSA and pricing data from SSR Health, LLC.¹⁰ The analysis estimated "that provider profits [from 340B sales] have more than doubled, from \$20.2 billion in 2015 to \$40.5 billion in 2019."¹¹

The combination of below average charitable care and high profitability provides evidence that too many of the current 340B covered entities are profiting from the government mandates without expanding access for underserved populations.

This analysis leverages the hospital data from CMS' Healthcare Provider Cost Reporting Information System (HCRIS) and the financial data reported to the IRS (the hospitals' 990 forms) for a sample of 340B hospitals to provide additional perspective on these questions. The review of the CMS data confirms that, relative to the average for all hospitals in the CMS database, 340B hospitals,

- tend to have higher profitability but
- provide a below average amount of charitable care.

The IRS 990 data provides a deeper dive into the financials of 340B hospitals based on a sample of 25 large tax-exempt 340B hospitals across eight states. The analysis reviews the recent average annual growth of hospital revenues, the growth in profits (or the excess of revenues over expenses for non-profit hospitals), profitability, and the number of contract pharmacies. Compared to key hospital or healthcare benchmarks, the data demonstrate that while these 340B hospitals are devoting fewer resources toward charitable care,

they are experiencing stronger than average revenue growth, better profitability, and greater profit growth. These hospitals also have a higher-than-average number of contract pharmacies – a large number of 340B contract pharmacies is associated with greater waste and inefficiencies.

Since the 340B program is materially improving the financial wellbeing of 340B hospitals, but not leading to a commensurate increase in charitable care, the analysis of these data provides further evidence that the 340B program requires fundamental reform.

Charity Care versus Uncompensated Care

To understand whether 340B hospitals are fulfilling the program's mission, it is important to distinguish between charity care and total uncompensated care. A hospital's uncompensated care

is the total monetary value of hospital-administered care for which no payment was received from either the patient or the insurer.

Charity care refers to treatment or services for which a hospital did not expect to receive payment because a patient was identified as unable to pay. This type of pro-bono funding is regulated by a hospital's charity care policy, and patient financial status and eligibility are typically determined before admission or care provision.¹²

The American Hospital Association (AHA) claims that total uncompensated care is the correct benchmark for evaluating whether 340B hospitals are fulfilling their mission.¹³ Similarly, a study by Dobson DaVanzo (2015) evaluated whether 340B hospitals are successfully serving vulnerable patients based on the amount of uncompensated care and its share of patients on Medicaid.¹⁴

It is important to note upfront that the large amount of uncompensated care is a significant problem for hospitals that must be addressed. Similarly, Medicare's and Medicaid's inadequate compensation formulas are also problematic and require reforms. However, the different definitions of uncompensated care compared to charity care illustrates why the share of resources devoted toward charity care is the correct benchmark for judging whether 340B hospitals are serving their intended populations.

The purpose of 340B is to help safety-net healthcare providers stretch their resources further so they can reach more low-income patients. Serving more low-income patients in this context refers to hospitals providing care without the expectation of funding. After all, if the full costs of services are being funded, then no discounts on drugs are required. When hospitals attempt to recoup the costs for care from patients or their insurers, the hospitals have deemed that these patients have sufficient resources to cover the costs of care, whether those resources are from private insurance or public assistance.

Simply because an insurer denied coverage does not mean that the hospital has expanded its attempts to serve low-income patients. Again, the flaws in the current insurance market, which include unreasonable coverage denials by insurers, are troubling and need to be fixed. However, these are different issues from the goal of the 340B program, which is neither designed to, nor capable of, fixing the flawed insurance model.

As for Medicaid, by its design, Medicaid patients already receive the best pricing on drugs. 340B discounts are not only unneeded for this population, covered entities are supposed to have processes in place to prevent duplicate discounts from occurring. While hospitals will often lose money treating Medicaid patients, fixing this problem requires reforms to the broader Medicaid system. Therefore, the share of Medicaid populations served does not reveal whether covered entities are using 340B revenues for the intended purposes either.

Therefore, it is inappropriate to include expenditures for total uncompensated care or the losses incurred when serving Medicaid patients when evaluating whether 340B resources are achieving their intended purpose. From the 340B perspective, it is only the hospital's expenditures on charity care that reflects their true pro bono outreach to vulnerable populations. With these caveats, this analysis emphasizes the trends for charity care when evaluating whether 340B hospitals are reaching the targeted population. However, because the AHA argues for the relevance of uncompensated care as the proper benchmark, the analysis also presents this data.

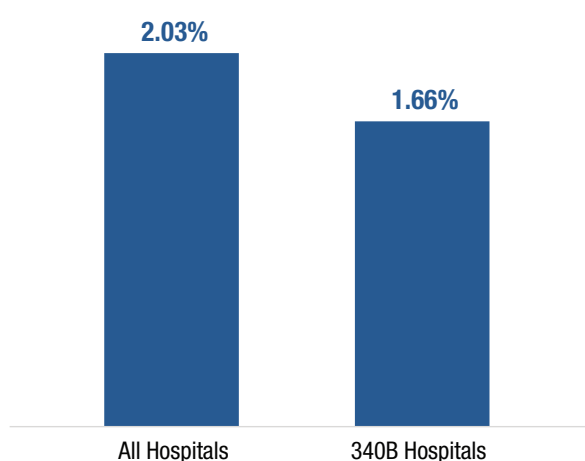
Below Average Charity Care, Above Average Profits

CMS' Healthcare Provider Cost Reporting Information System (HCRIS) provides information on hospitals including facility characteristics, utilization data, and financial data that include each hospital's cost of charity care and uncompensated care.¹⁵ Of course, the total cost of charity care and uncompensated costs will depend on the hospital's size. Therefore, the relevant benchmark for evaluating how effectively a hospital system is reaching the targeted population is total charity care relative to total net patient revenues and total uncompensated care relative to total net patient revenues. Based on these benchmarks, 340B hospitals are less charitable than the average hospital.

Starting with the provision of charity care, Figure 1 presents the sum of the charity care expenditures for all the hospitals in the CMS database divided by the sum of the hospitals' net revenues¹⁶ (noted as All Hospitals). Overall, hospitals in 2017 devoted 2.03 percent of their net patient revenues toward charitable care. The "340B Hospitals" data point in Figure 1 is estimated similarly, but for only those hospitals in the CMS database that are designated as a 340B hospital.

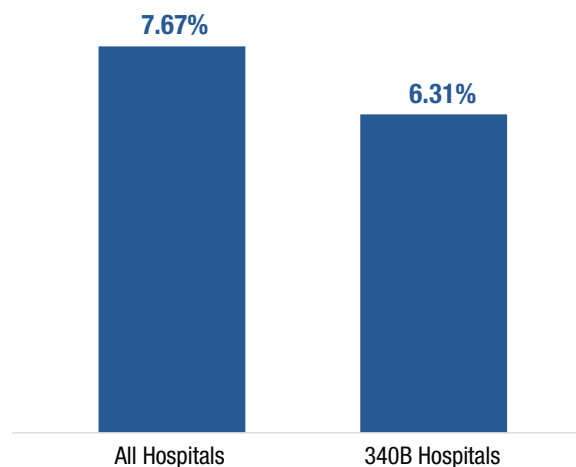
A hospital's 340B status was based on the list of current 340B covered entities maintained by the Health Resources & Services Administration, Office of Pharmacy Affairs 340B OPAIS.¹⁷ Compared to overall hospital spending, charitable spending as a share of net patient revenues by 340B hospitals was only 1.66 percent. Consequently, despite the 340B mission of extending hospital resources to reach more low-income patients, 340B hospitals devote fewer resources to providing charity care than the average hospital.

FIGURE 1. Charity Care as a Percentage of Net Patient Revenues*
All Hospitals versus 340B Hospitals, 2017



Source: Author calculations based on CMS Medicare Hospital Cost Report Data
* Revenues are reported as "Net Patient Revenue" and account for discounts and concessions.

FIGURE 2. Uncompensated Care as a Percentage of Net Patient Revenues*
All Hospitals versus 340B Hospitals, 2017



Source: Author calculations based on CMS Medicare Hospital Cost Report Data
* Revenues are reported as "Net Patient Revenue" and account for discounts and concessions.

While less relevant, Figure 2 demonstrates that 340B hospitals are not providing more uncompensated care than the average hospital either. Using the same methodology behind Figure 1, Figure 2 presents the share of uncompensated care relative to net revenues for all hospitals and 340B hospitals. As Figure 2 demonstrates, while all hospitals' uncompensated care in 2017 equaled 7.67 percent of net revenues, uncompensated care at 340B hospitals was a lower 6.31 percent.

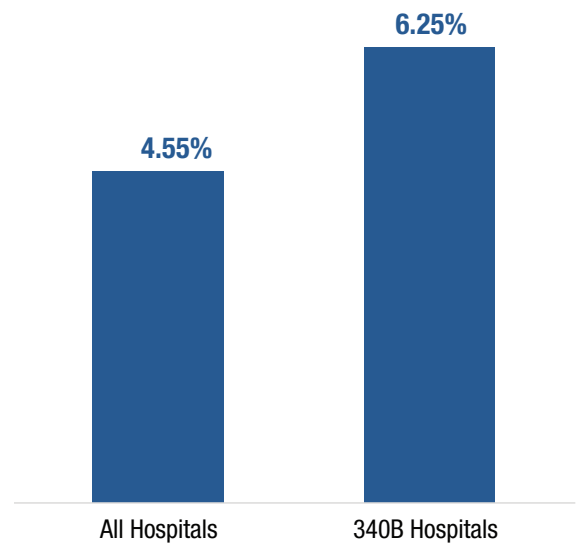
These findings are particularly troubling because, based on the same database, 340B hospitals are more profitable than the average hospital. Using the same methodology as in Figures 1 and 2 for each hospital's net income relative to net revenue demonstrates that the profitability (or excess of revenues over costs for non-profit hospitals) of 340B hospitals was 37 percent larger (6.25 percent compared to 4.55 percent) at 340B hospitals compared to the average of all hospitals.

These data are for a single year, 2017, however. It is also important to understand whether 340B hospitals are experiencing faster revenue and profitability growth relative to the industry average. To provide perspective on these growth trends, the publicly available IRS form 990s were examined for a sample of twenty-five large 340B hospitals. The hospitals operate across eight states (Colorado, Florida, Iowa, Michigan, Minnesota, Massachusetts, Ohio, and Pennsylvania) that are diverse geographically and demographically.¹⁸

When compared against relevant industry benchmarks, this examination confirms the trends from the CMS data and provides additional support that hospitals are reaping financial benefits from their 340B status without a commensurate increase in the amount of charity care provided. Specifically, while providing less charity care, these 340B hospitals are experiencing significantly stronger revenue growth, faster profit growth, and better profitability.

To illustrate how the sample of 340B hospitals compare to the CMS data just reviewed, the charity care and profitability data are presented first. Starting with the charity care data, the sample of 340B hospitals devote fewer relative resources toward charity care compared to the 340B hospitals based on the CMS HCRIS dataset, see Figure 4. While overall 340B hospitals spent 1.66 percent on charity care, which is still less than the 2.03 percent all CMS hospitals spent, the sample of 25 hospitals only spent 0.66 percent (based on the median hospital spending) or 1.04 percent (based on the arithmetic average), which is close to the weighted average of 1.2 percent (not shown in Figure 4).

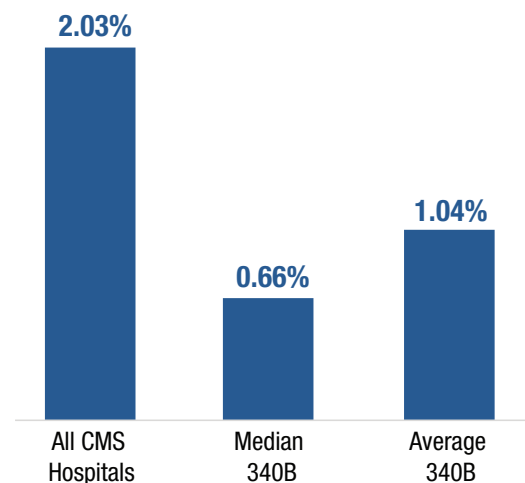
**FIGURE 3. Net Income as a Percentage of Net Patient Revenues*
All Hospitals versus 340B Hospitals, 2017**



Source: Author calculations based on CMS Medicare Hospital Cost Report Data

* Revenues are reported as "Net Patient Revenue" and account for discounts and concessions.

**FIGURE 4. Charity Care as a Percentage of Revenues*
All Hospitals versus Sample of 340B Hospitals, 2017**



Sources: Author calculations based on CMS Medicare Hospital Cost Report Data and individual hospital 990 filings for 2018/2019.

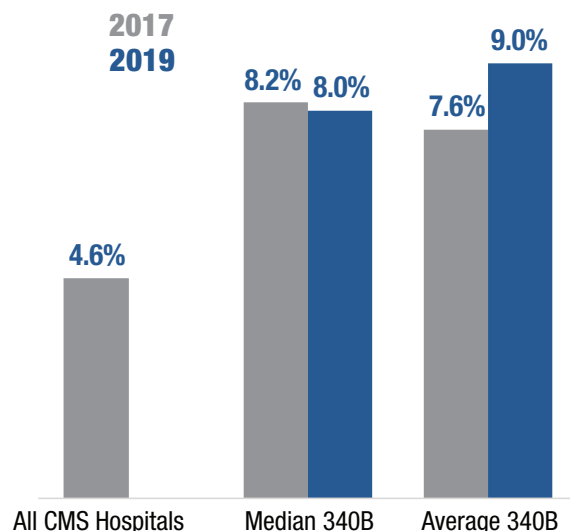
* Revenues are reported as "Net Patient Revenue" and account for discounts and concessions.

With respect to profitability, the sample of twenty-five 340B hospitals have a higher average profitability than the average for all 340B hospitals based on the CMS HCRIS dataset. To account for the fact that the 990s data are for a more recent year (2018 or 2019) than the CMS data (2017) both the 2017 profitability data and the profitability data for the latest year available are presented in Figure 5. Figure 5 demonstrates that, particularly for the median hospital in the 340B sample, the 2019 profitability is similar to the 2017 profitability. Further, these profitability rates are nearly 80 percent larger than the profitability for all hospitals and nearly one-third higher than the profitability for the average 340B hospital.

Figure 6 illustrates that the average annual revenue growth at a 340B hospital was between 5.0 percent (based on the median) and 6.5 percent (based on the arithmetic average) between 2010 and 2019. According to the CMS National Health Expenditure data, the average annual growth in hospital care expenditures was 4.4 percent. Consequently, expenditures for this sample of 340B hospitals grew 47 percent faster than the national average expenditure growth for hospital care.¹⁹

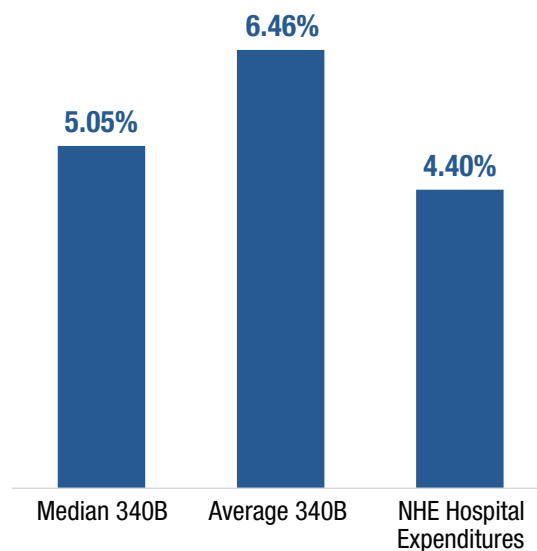
Not only are revenues growing faster, but the fast revenue growth is translating into strong growth in profits (or the excess of revenues over expenses in the case of non-profits). In fact, the average annual growth in profits for the sample of 340B hospitals has been even faster than the average annual growth in revenues and faster than the average annual growth in profits for the hospital sector and economy overall, see Figure 7. The over 9 percent average annual growth rate in profits (based on the median hospital) for the sample of 340B hospitals is 265 percent higher than the average profitability growth at hospitals and nursing care centers over this period according to the Bureau of Economic Analysis (BEA) National Income and Products Account.²⁰

**FIGURE 5. Hospital Profitability
All Hospitals (2017) versus
Sample of 340B Hospitals (2017 and 2019*)**



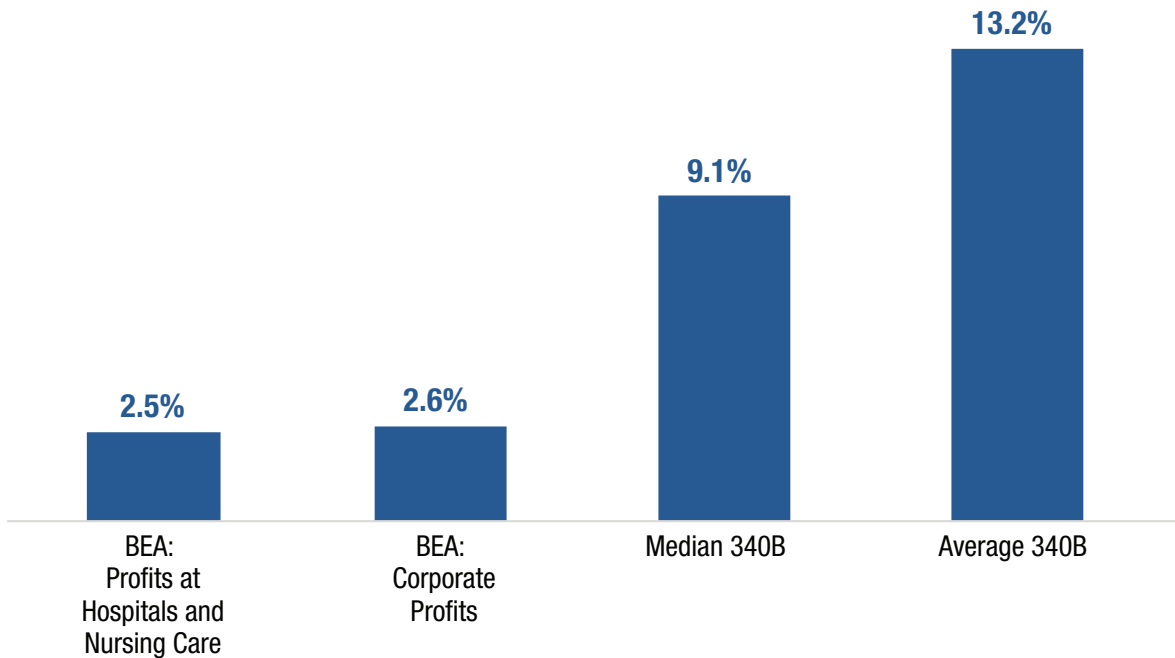
Sources: Author calculations based on CMS Medicare Hospital Cost Report Data and individual hospital 990 filings for 2018/2019.
* Where 2019 990s were unavailable, the 2018 data was analyzed.

**FIGURE 6. Average Annual Revenue Growth
All Hospitals versus Sample of
340B Hospitals, 2010 – 2019***



Sources: Author calculations based on CMS Medicare Hospital Cost Report Data and individual hospital 990 filings for 2018/2019.
* For hospitals where 2019 990s were unavailable, the 10-year comparison is between 2009 and 2018.

**FIGURE 7. Average Annual Profit Growth
All Hospitals versus Sample of 340B Hospitals, 2010 – 2019***



*Sources: Author calculations based on BEA and 990 filings for 2018/2019.
* For hospitals where 2019 990s were unavailable, the 10-year comparison is between 2009 and 2018.*

These data indicate that while 340B hospitals provide less charity care compared to non-340B hospitals, they have also experienced stronger revenue growth, faster profit growth, and have higher profit margins. These data support the contention that the 340B program requires reforms.

The Contract Pharmacy Loophole

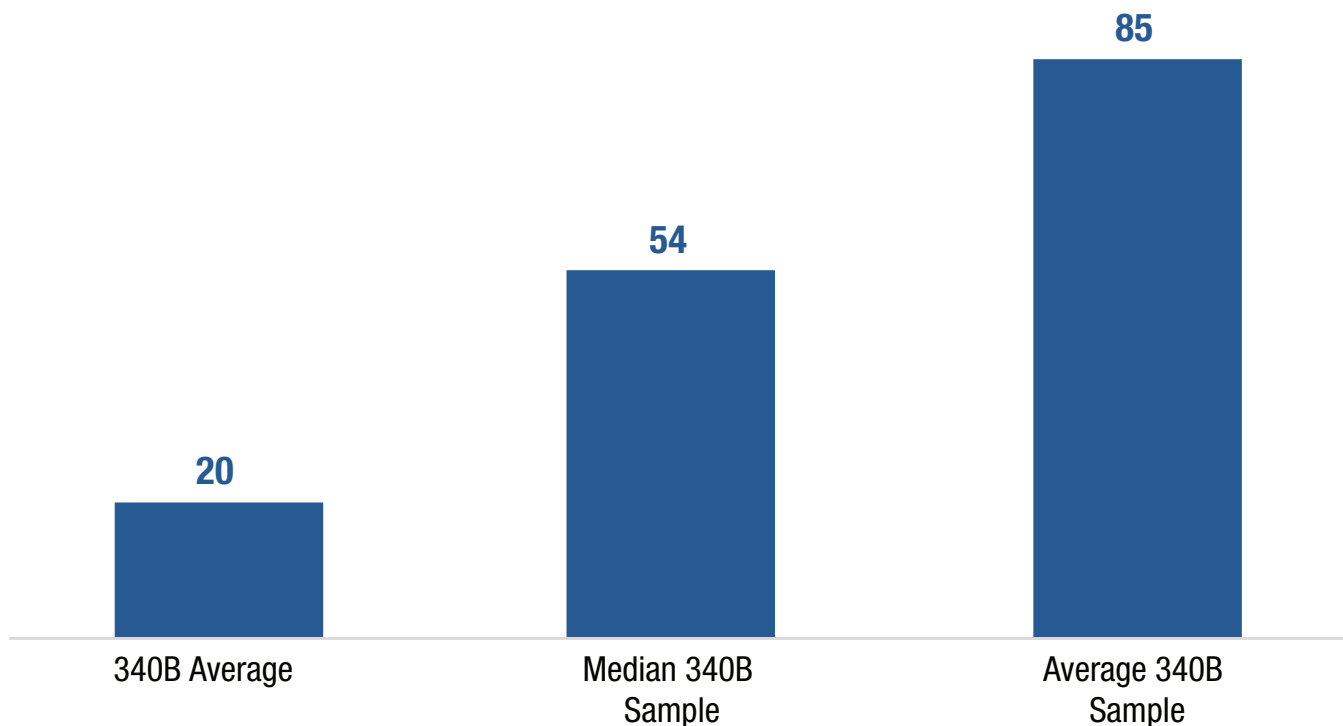
One important area in need of reform is the explosive growth in contract pharmacies. Contract pharmacies are retail pharmacies located outside of the hospital or covered entity. Their purpose is to expand access to affordable medicines for a covered entity's 340B eligible patients. As we explained in our 2017 analysis,

previously, HRSA only allowed safety-net clinics without an in-house pharmacy to contract out its pharmacy services to a retail pharmacy. The 2010 guidance allowed any covered entity, including large hospitals, to establish unlimited relationships with contract pharmacies.

This change was a clear example of administrative overreach given that contract pharmacies were never part of the 1992 law. Some hospitals have responded by building networks of hundreds of contract pharmacies that includes Walgreens, Rite Aid, CVS, and Wal-Mart – private, for-profit companies that clearly do not require government support. These eligibility expansions, coupled with the allure of government guaranteed profits, have encouraged adverse consequences, none of which are surprising.²¹

These adverse consequences have included the “diversion of 340B discounted medicines to non 340B-eligible patients, receiving duplicate discounts from both Medicaid and the 340B program when such duplication is prohibited, and not offering the 340B discounted price to uninsured patients, the raison d’etre of the program.”²² The exponential growth of the number of contract pharmacies from “2,321 in 2010 to just above 100,000 in 2020” illustrates that the problems created by allowing an excessive amount of contract pharmacies is increasing.²³ The sample of 340B hospitals examined here supports the contention that covered entities are entering into too many contract pharmacy arrangements. While the average 340B Hospital has 20 contract pharmacies, an excessive amount relative to the original intention of one contract pharmacy, the median hospital from the 340B sample has 54.

FIGURE 8
Number of Contract Pharmacies for 340B Hospital
340B Hospital Average Compared to Average and Median for Sample of 340B Hospitals



Sources: Author calculations based on individual hospital 990 filings for 2018/2019 and Masia (2021).

Due to the strong association between a large number of contract pharmacies and problems of diversion and low-income patients failing to benefit from the low 340B prices, the large numbers of contract pharmacies for this sample of 340B hospitals is troubling. These results confirm that returning the contract pharmacy provisions to their original intent is an important component of a comprehensive 340B reform program.

Conclusion: Reforms Should Return 340B to Its Original Purpose

Hospital data collected by the Centers for Medicare and Medicaid Services (CMS) demonstrates that 340B hospitals provide less total charity care as a share of revenues than the industry average. Combined with the IRS 990 forms from a sample of large 340B hospitals, the data also illustrate that the extreme growth in the 340B program has coincided with a marked improvement in the financial health of the 340B hospitals. These trends are not a coincidence as 340B has become a substantial revenue generator for covered entities.

The purpose of the 340B program is to improve low-income patients' access to healthcare and drugs, it was never meant to be a financial windfall for profitable healthcare institutions. Since 340B revenues are growing robustly without a commensurate increase in the amount of charity care, fundamental reforms to the program are required. These reforms should increase the stringency of the program to require that 340B healthcare providers and hospital systems serve the intended low-income populations, ensure that patients directly benefit from the financial discounts when receiving their medications, and restrict the scale and scope of the contract pharmacy program.

While the intentions to expand healthcare services to vulnerable populations are laudable, the 340B program is failing to serve this purpose. Instead, the program has become an unwarranted subsidy for many large hospitals. And, while there are many policy disincentives that are unjustifiably harming hospitals' financial viability, the purpose of 340B is not to compensate for these costs. It is past time to reform 340B.

Appendix: Select Data from Sample of 25 340B Hospitals

Key revenue, profit, and contract pharmacy data for the sample of 25 hospitals, including links to the data sources, are listed below.

Baptist Hospital of Miami - [2018 Revenue](#): \$1,717,731,038, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 2.69%, [Charity Care/Net Revenue](#): 1.57%, [2 Active Pharmacy Contracts](#)

Baystate Medical Center – [2018 Revenue](#): \$1,389,295,156, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.81%, [Charity Care/Net Revenue](#): 0.66%, [155 Active Pharmacy Contracts](#)

Beth Israel Deaconess Medical Center – [2017 Revenue](#): \$1,910,232,799, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.47%, [Charity Care/Net Revenue](#): 0.33%, [323 Active Pharmacy Contracts](#)

Covenant Medical Center – [2018 Revenue](#): \$693,118,114, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.09%, [Charity Care/Net Revenue](#): 0.08%, [28 Active Pharmacy Contracts](#)

Essentia Health – [2018 Revenue](#): \$194,220,633, [Recent Executive Pay](#); St. Mary's Duluth [Charity Care/Net Patient Revenue](#): 0.73%, St. Mary's Duluth [Charity Care/Net Revenue](#): 1.60%, Essentia [140 Active Pharmacy Contracts](#)

Genesis Health – [2019 Revenue](#): \$530,251,339, [Recent Executive Pay](#), Davenport [Charity Care/Net Patient Revenue](#): 0.68%, Davenport [Charity Care/Net Revenue](#): 0.44%, Genesis [128 Active Pharmacy Contracts](#)

Good Samaritan Hospital – [2018 Revenue](#): \$636,974,671, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.66%, [Charity Care/Net Revenue](#): 0.64%, [168 Active Pharmacy Contracts](#)

Lancaster General Hospital – [2018 Revenue](#): \$1,145,850,529, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.28%, [Charity Care/Net Revenue](#): 0.25%

Lehigh Valley Hospital: [2018 Revenue](#): \$2,153,060,563, [Recent Executive Pay](#), Lehigh Valley [Charity Care/Net Patient Revenue](#): 0.70%, [Charity Care/Net Revenue](#): 0.77%, [111 Active Pharmacy Contracts](#)

Lowell General Hospital – [2017 Revenue](#): \$496,748,443, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.70%, [Charity Care/Net Revenue](#): 0.62%, [70 Active Pharmacy Contracts](#)

Mass General Brigham – 2019 Revenue: \$16,841,143,738, [Recent Executive Pay](#), Mass General Hospital [Charity Care/Net Patient Revenue](#): 0.69%, Mass General Hospital [Charity Care/Net Revenue](#): 0.11%, Mass General Brigham [235 Active Pharmacy Contracts](#)

Miami Valley Hospital – [2018 Revenue](#): \$966,821,389, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 1.36%, [Charity Care/Net Revenue](#): 1.06%, [141 Active Pharmacy Contracts](#)

MidMichigan Medical Center – [2018 Revenue](#): \$483,794,335, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.22%, [Charity Care/Net Revenue](#): 0.18%, [17 Active Pharmacy Contracts](#)

Munson Medical Center – [2017 Revenue](#): \$652,747,521, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.20%, [Charity Care/Net Revenue](#): 0.18%, [54 Active Pharmacy Contracts](#)

Orlando Health - [2018 Revenue](#): \$2,756,773,707, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 4.32%, [Charity Care/Net Revenue](#): 3.19%, [9 Active Pharmacy Contracts](#)

Parkview Medical Center - [2018 Revenue](#): \$524,724,626, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.57%, [Charity Care/Net Revenue](#): 0.38%

Regions Hospital - [2018 Revenue](#): \$805,358,194, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 1.19%, [Charity Care/Net Revenue](#): 1.09%, [93 Active Pharmacy Contracts](#)

Saint Joseph Hospital - [2019 Revenue](#): \$614,821,512, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 1.52%, [Charity Care/Net Revenue](#): 1.40%, [15 Active Pharmacy Contracts](#)

St. Cloud Hospital - [2018 Revenue](#): \$991,836,027, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.03%, [Charity Care/Net Revenue](#): 0.03%, [31 Active Pharmacy Contracts](#)

St. Joseph's Hospital - [2019 Revenue](#): \$1,373,992,276, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 4.04%, [Charity Care/Net Revenue](#): 3.62%, [23 Active Pharmacy Contracts](#)

St. Luke's Methodist Hospital - [2018 Revenue](#): \$415,656,187, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.19%, [Charity Care/Net Revenue](#): 0.16%, [5 Active Pharmacy Contracts](#)

Valley View Hospital Association - [2019 Revenue](#): \$261,247,335, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 1.05%, [Charity Care/Net Revenue](#): 0.91%

William Beaumont Hospital - [2018 Revenue](#): \$2,959,634,869, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.53%, [Charity Care/Net Revenue](#): 0.26%, [214 Active Pharmacy Contracts](#)

Yampa Valley Medical Center - [2019 Revenue](#): \$115,114,216, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.21%, [Charity Care/Net Revenue](#): 0.17%

York Hospital - [2018 Revenue](#): \$1,235,069,876, [Recent Executive Pay](#), [Charity Care/Net Patient Revenue](#): 0.10%, [Charity Care/Net Revenue](#): 0.08%

Endnotes

- 1 “340B Drug Discount Program: Increased oversight needed to ensure nongovernmental hospitals meet eligibility requirements” Government Accountability Office, GAO-20-108, December 2019, <https://www.gao.gov/assets/gao-20-108.pdf>.
- 2 Healthcare Provider Cost Reporting Information System (HCRIS) Cost Reports, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports>.
- 3 Health Resources & Services Administration (HRSA) Office of Pharmacy Affairs 340B OPAIS, <https://340bopais.hrsa.gov/CoveredEntitySearch/000083563> (accessed October 7, 2021).
- 4 Winegarden W “Addressing the Problems of Abuse in the 340B Drug Pricing Program” Pacific Research Institute, December 2017, https://medecon.org/wp-content/uploads/2019/03/340B-Study_FINAL.pdf.
- 5 “340B Drug Discount Program: Increased oversight needed to ensure nongovernmental hospitals meet eligibility requirements” Government Accountability Office, GAO-20-108, December 2019, <https://www.gao.gov/assets/gao-20-108.pdf>.
- 6 Fein A “New HRSA Data: 340B Program Reached \$29.9 Billion in 2019; Now Over 8% of Drug Sales” Drug Channels, June 9, 2020, <https://www.drugchannels.net/2020/06/new-hrsa-data-340b-program-reached-299.html>.
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- 8 “Left Behind: An analysis of charity care provided by hospitals enrolled in the 340B discount program” AIR340B, November 2019.
- 9 Ibid.
- 10 Masia N “340B Drug Pricing Program: Analysis Reveals \$40 Billion in Profits in 2019” AIR340B, May 2021, <https://340breform.org/wp-content/uploads/2021/05/AIR340B-Neal-Masia-Report.pdf>.
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- 12 “Balancing Uncompensated Care and Hospital Bad Debt” Definitive Healthcare Blog, January 2020, <https://www.definitivehc.com/blog/balancing-uncompensated-care-and-hospital-bad-debt> (accessed October 12, 2021).
- 13 “Setting the Record on 340B: Fact vs. Fiction” American Hospital Association, March 2021.
- 14 “Analysis of 340B DSH Hospital Services Delivered to Vulnerable Patient Populations” Dobson Davanzo, June 2, 2015.
- 15 Healthcare Provider Cost Reporting Information System (HCRIS) Cost Reports, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports>.
- 16 Net revenues account for all discounts and concessions.

17 Health Resources & Services Administration (HRSA) Office of Pharmacy Affairs 340B OPAIS, <https://340bopais.hrsa.gov/CoveredEntitySearch/000083563> (accessed October 7, 2021).

18 The hospitals examined included:

Baptist Health of Miami	Lowell General Hospital	Saint Joseph Hospital
Baystate Medical Center	Mass General Brigham	St. Cloud Hospital
Beth Israel Deaconess Medical Center	Miami Valley Hospital	St. Joseph's Hospital
Covenant Medical Center	Mid-Michigan Medical Center	St. Lukes Methodist Hospital
Essentia Health (SMDC Medical Center)	Munson Medical Center	Valley View Hospital Association
Genesis Health	Orlando Health	William Beaumont Hospital
Good Samaritan Hospital of Cincinnati	Parkview Medical Center	Yampa Valley Medical Center
Lancaster General Hospital	Regions Hospital	York Hospital
Lehigh Valley Hospital		

19 Total expenditures on hospital care is from the National Health Expenditure Tables maintained by CMS, Table 2, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData>.

20 See BEA NIPA Table 6.17.D “Corporate Profits Before Tax By Industry”, www.bea.gov.

21 Winegarden W “Addressing the Problems of Abuse in the 340B Drug Pricing Program” Pacific Research Institute, December 2017, https://medecon.org/wp-content/uploads/2019/03/340B-Study_FINAL.pdf.

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23 Masia N “340B Drug Pricing Program: Analysis Reveals \$40 Billion in Profits in 2019” AIR340B, May 2021, <https://340breform.org/wp-content/uploads/2021/05/AIR340B-Neal-Masia-Report.pdf>.

About the Author

Wayne Winegarden, Ph.D., is a Sr. Fellow in Business & Economics, Pacific Research Institute, as well as the Director of PRI's Center for Medical Economics and Innovation.

Dr. Winegarden's policy research explores the connection between macroeconomic policies and economic outcomes, with a focus on fiscal policy, the health care industry, and the energy sector. As Director of the Center for Medical Economics and Innovation, Dr. Winegarden spearheads research and advances policies that support the continued viability and vitality of the U.S. biomedical and pharmaceutical industries to the benefit of patients and overall economic growth.

Dr. Winegarden's columns have been published in the *Wall Street Journal*, *Chicago Tribune*, *Investor's Business Daily*, *Forbes.com*, and *USA Today*. He was previously economics faculty at Marymount University, has testified before the U.S. Congress, has been interviewed and quoted in such media as CNN and Bloomberg Radio, and is asked to present his research findings at policy conferences and meetings.

Dr. Winegarden is also the Principal of an economic advisory firm that advises clients on the economic, business, and investment implications from changes in broader macroeconomic trends and government policies. Clients have included Fortune 500 companies, financial organizations, small businesses, and trade associations. Previously, Dr. Winegarden worked as a business economist in Hong Kong and New York City; and a policy economist for policy and trade associations in Washington D.C. Dr. Winegarden received his B.A., M.A., and Ph.D. in Economics from George Mason University.

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MAILING ADDRESS

PO Box 60485
Pasadena, CA 91116

SAN FRANCISCO OFFICE

601 California Street
Suite 620
San Francisco, CA 94108
Tel 415-989-0833

SACRAMENTO OFFICE

2110 K Street, Suite 28
Sacramento, CA 95816
Tel 916-389-9774

PASADENA OFFICE


680 E. Colorado Blvd., Suite 180
Pasadena, CA 91101
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