“Unfulfilled Expectations: An analysis of charity care provided by 340B hospitals”

Media Q&A

QUESTION: Shouldn’t the report have analyzed uncompensated care and not charity care?

ANSWER: Uncompensated care includes bad debt that was charged to a patient, but was not paid. According to the Healthcare Financial Management Association (HFMA), “bad debts result when a patient who has been determined to have the financial capacity to pay for healthcare services is unwilling to settle the claim, whereas charity care is provided to a patient with demonstrated inability to pay.”¹ Thus, uncompensated care is not the right measure for this analysis.

This paper’s focus on charity care is consistent with the 340B program’s intent, which was to restore previously provided prescription drug discounts to safety net providers so that these providers could devote more of the federal resources they receive to sustain care for the vulnerable, uninsured and indigent. Nothing in the legislative history suggests that Congress created the 340B program to compensate hospitals for situations where patients whose income or assets disqualify them from charity care programs and are unwilling or unable to pay their bills.

QUESTION: Don’t we need 340B to compensate hospitals for low Medicaid reimbursement?

ANSWER: That is not what 340B was designed for – it is intended for patients, not as a benefit to hospitals. Brand pharmaceutical companies already provide deep statutory discounts to Medicaid, and those discounts were both increased in the Affordable Care Act and extended to tens of millions of people in Medicaid managed care plans.

QUESTION: How does the Medicare cost report data used in the study differ from the IRS form 990 data?

ANSWER: The IRS form 990 asks hospitals to report the percent of total expenses attributable to charity care at cost. In the study, “Unfulfilled Expectations,” analysts did not use this data because it is only available for non-profit hospitals, since for-profit hospitals are not required to file 990s. As part of our report, we wanted to compare 340B hospitals’ provision of charity care to the provision of charity care by all hospitals.

The charity care data reported in Medicare cost reports is used by the Department of Health and Human Services (HHS) to help determine Electronic Health Record incentive payments. In its final rule on Electronic Health Record payments, HHS stated, “We believe that the charity care charges reported on line 20 of the pending final Office of Management and Budget-approved Worksheet S–10 represent the most accurate measure of charity care charges as part of the hospital’s overall reporting of uncompensated and indigent care for Medicare purposes.”²

² Federal Register, Vol. 75, No. 144.
Additionally, Avalere employed techniques described in the appendix of “Unfulfilled Expectations” to exclude hospitals with data reporting errors.

Finally, hospitals have to certify that the data they submit (including the charity care data) on their Medicare cost reports is correct. The first page of the cost report states “misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law.”

**QUESTION:** This paper makes the case that Disproportionate Share Hospital (DSH) is not the appropriate metric for 340B eligibility. What do you think is an appropriate metric for 340B eligibility?

**ANSWER:** The AIR 340B coalition would like to work with Congress to develop a more appropriate set of eligibility criteria that would be accompanied by strong oversight to ensure that the program aligns more closely with Congress’s original intent. That intent was to limit the program to specified federally funded clinics and certain nonprofit hospitals that provide direct clinical care to large numbers of uninsured Americans.

**QUESTION:** Isn’t the average charity care level for 340B hospitals higher than the average charity care level for non-340B hospitals?

**ANSWER:** This study doesn’t look at averages, it assesses whether all 340B hospitals are providing high levels of charity care, as the law intended. What it finds is that the vast majority are not. That said, there is a small group of 340B hospitals that provide significant levels of charity care, as the law intended. About 16% of 340B hospitals provide charity care that represents 5% or more of their total patient costs. These hospitals, of course, are reflected in the averages as well.

**QUESTION:** Why should Congress care? Isn’t this just a dispute between two sectors?

**ANSWER:** Large public health programs like 340B provide tools that can assist the neediest among us to get much-needed health care, which can help prevent public health crisis from ever occurring. That is something that patient and provider groups, manufacturers and many hospitals and clinics agree on. When these programs designed to assist vulnerable, low-income, uninsured people are abused, it can undermine future efforts to help vulnerable, uninsured patients by breeding cynicism about government’s ability to develop and sustain programs that effectively serve the most vulnerable.

**QUESTION:** How much does 340B cost the pharmaceutical industry? Isn’t it just 2% of sales?

**ANSWER:** The 340B program is important today and going forward for the many patients that depend on it. Yet, the program continues to grow exponentially without appropriate guardrails to ensure that the program fulfills its promise to patients. Pharmaceutical manufacturer participation in 340B is focused on ensuring vulnerable, uninsured, indigent patients gain better access to prescription medicines.

**QUESTION:** How are patients harmed?

**ANSWER:** The Congressional intent of the 340B program was to ensure that 340B benefits flow to the individuals whom Congress sought to help, namely vulnerable, uninsured patients. However, the report findings raise questions as to the extent to which vulnerable patients are being helped by the 340B program. Under the current 340B law, hospitals have no requirement to pass savings from the program directly to patients in need. While 16% of covered entities that participate in the program appear to be providing significant levels of charity care to patients (representing 5% or more of their patient costs), it is concerning that nearly three-quarters of...
340B hospitals are providing less charity care as a percent of patient costs compared to the total for all hospitals—including for profit hospitals. This raises questions as to whether the current eligibility criteria for hospitals are closely targeting those hospitals that serve as a safety net for vulnerable patients. It also raises questions about the extent to which vulnerable patients are directly benefitting from the 340B program, and whether eligibility criteria that provide no incentive to pass along savings or provide a sufficient level of charity care have left patients in the lurch as hospitals continue to profit off the program.

**QUESTION:** You say the program was intended to help vulnerable and uninsured patients, but others say that the program was intended to help safety net facilities stretch scarce federal resources. Which one is right?

**ANSWER:** The purpose of the 340B program was to ensure that the program served vulnerable and uninsured patients. Congress chose to achieve that goal by designating certain providers they thought would serve as safety net providers/stewards of the benefit for that patient population. As it stands today, many 340B DSH hospitals are not meeting that goal. Covered entities are supposed to be stewards of the benefit, not the direct beneficiaries. The program was certainly never intended to allow hospitals to charge patients higher drug prices on resale. Additionally, revenue derived from the 340B program does not reduce government DSH payments, as some have implied.

**The legislative history:**
Congress created the 340B program to help federal grantees and true safety net hospitals serving vulnerable uninsured patients by reinstating the deep discounts that manufacturers had voluntarily provided to these facilities before enactment of the 1990 Medicaid drug rebate statute. Before the Medicaid rebate program was established, prescription drug manufacturers voluntarily offered significant discounts to many entities serving needy patient populations. However, the Medicaid drug rebate statute failed to exempt these discounts from the Medicaid “best price” provision, a factor that may have impacted manufacturers’ voluntary discounts due to its potential market-wide effects. Congress responded by exempting discounts to these facilities and re-establishing the discounts federal grantees, and certain hospital entities serving uninsured indigent patients, had been receiving before enactment of the Medicaid rebate statute, explaining that the 340B legislation “provides protection from drug price increases to specified federally funded clinics and public hospitals that provide direct clinical care to large numbers of uninsured Americans” [emphasis added]. Referring to one of the 340B hospital eligibility categories, the legislative history similarly stated that the 340B program was meant to allow participation by a private nonprofit hospitals that contract to care for “low-income individuals who are not eligible for Medicaid or Medicare”—i.e., who are uninsured—but not by a private nonprofit hospital with “a minor contract to provide indigent care which represents an insignificant portion of its operating revenues.”

**QUESTION:** You’ve only talked about hospitals qualifying on the basis of their DSH percentage. What about 340B and community health centers (CHCs), as well as the other types of hospitals, such as critical access hospitals and rural hospitals?

**ANSWER:** This study did not focus on CHCs, critical access hospitals, rural referral centers, or other entities eligible for 340B by their grant status. These entities clearly have an important role to play in our public health safety net. AIR340B would welcome the chance to sit down with key provider subsets and learn more about how they engage with the program, and what they think can be done to help address some of the current short-comings while assisting them in their role of providing care for truly vulnerable patients.

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