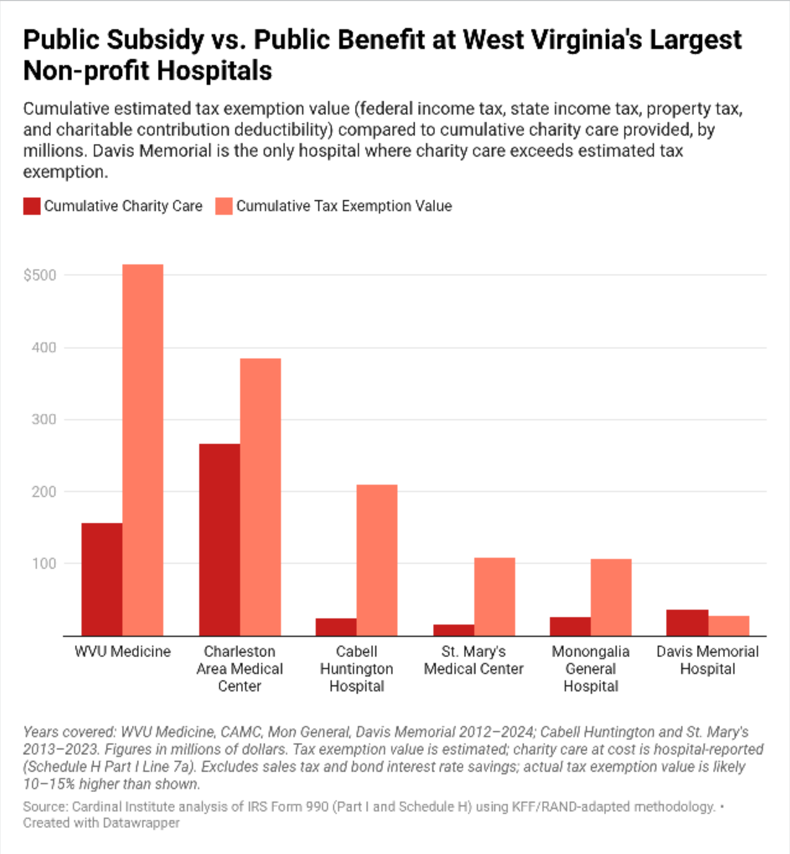
THE 340B DRUG PRICING PROGRAM IN WEST VIRGINIA:
ANOTHER MISSING LAYER OF HOSPITAL ACCOUNTABILITY

West Virginia's biggest non-profit hospital systems enjoy a suite of public advantages. They pay no federal, state, or local income or property taxes. State law, through the Certificate of Need process, shields them from new competition by requiring government sign-off before any new hospital or service can open its doors. On top of that, the federal 340B program allows these hospitals to buy prescription drugs at steep discounts, then bill insurers at the full price—pocketing the difference as extra revenue.

In theory, these perks come with strings attached: hospitals are expected to provide free or discounted care to those who can't pay, and to support their communities in broader ways. In reality, West Virginians rarely have a clear window into whether hospitals are keeping that promise.

This report takes a closer look at the 340B program—another major public benefit flowing to these hospitals—and finds a familiar story. As with tax breaks and CON rules that keep out competition, there is no way for West Virginians to see what, if anything, the 340B program delivers in return for all the dollars it generates.

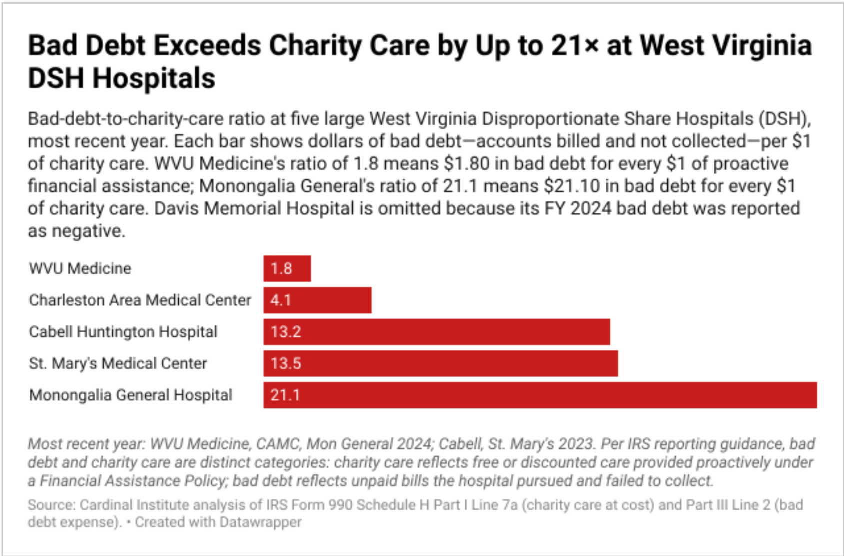
For this analysis, I zeroed in on six non-profit hospitals: WVU Medicine, Charleston Area Medical Center (CAMC), Cabell Huntington Hospital, St. Mary's Medical Center, Monongalia General Hospital, and Davis Memorial Hospital. These are the flagship acute-care hospitals at the heart of West Virginia's largest systems.



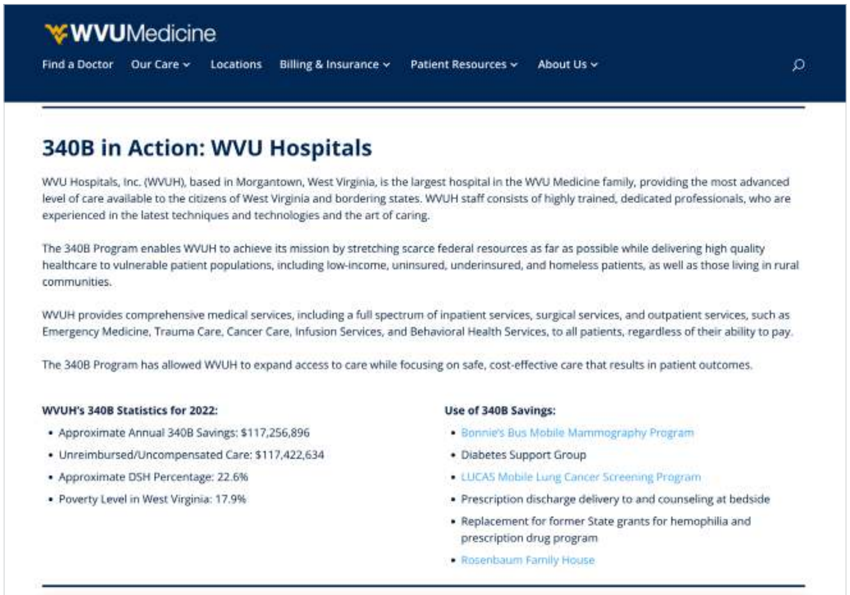
The Findings

The five largest hospitals in this analysis captured more in estimated tax benefits than they delivered in free or discounted care to patients in every year studied. Combined gap across the five hospitals: approximately $835 million between 2012 and 2024.

At every hospital examined, the amount sent to collections (called "bad debt") far exceeded the amount of free or discounted care provided. The ratio ranges from less than two-to-one at WVU Medicine to more than twenty-one-to-one at Monongalia General Hospital. Where hospitals report it, roughly one in five dollars sent to collections represents bills owed by patients who would have qualified for financial assistance if the hospital had screened them up front.



Only one West Virginia hospital—WVU Medicine—has ever publicly disclosed how much 340B revenue it receives, and that disclosure consists of a single 2022 number published on the hospital's corporate website as part of material defending the program.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340B in Action: WVU Hospitals

WVU Hospitals, Inc. (WVUH), based in Morgantown, West Virginia, is the largest hospital in the WVU Medicine family, providing the most advanced level of care available to the citizens of West Virginia and bordering states. WVUH staff consists of highly trained, dedicated professionals, who are experienced in the latest techniques and technologies and the art of caring.

The 340B Program enables WVUH to achieve its mission by stretching scarce federal resources as far as possible while delivering high quality healthcare to vulnerable patient populations, including low-income, uninsured, underinsured, and homeless patients, as well as those living in rural communities.

WVUH provides comprehensive medical services, including a full spectrum of inpatient services, surgical services, and outpatient services, such as Emergency Medicine, Trauma Care, Cancer Care, Infusion Services, and Behavioral Health Services, to all patients, regardless of their ability to pay.

The 340B Program has allowed WVUH to expand access to care while focusing on safe, cost-effective care that results in patient outcomes.

WVUH's 340B Statistics for 2022:

- Approximate Annual 340B Savings: $117,256,896
- Unreimbursed/Uncompensated Care: $117,422,634
- Approximate DSH Percentage: 22.6%
- Poverty Level in West Virginia: 17.9%

Use of 340B Savings:

- Bonnie's Bus Mobile Mammography Program
- Diabetes Support Group
- LUCAS Mobile Lung Cancer Screening Program
- Prescription discharge delivery to and counseling at bedside
- Replacement for former State grants for hemophilia and prescription drug program
- Rosenbaum Family House

West Virginia's Public Employees Insurance Agency (PEIA), the state agency that provides health coverage for about 235,000 West Virginians, has identified 340B as a documented driver of rising drug costs to the plan. In a December 2024 report to the West Virginia Legislature, PEIA reported that its drug costs grew 24.4% in a single year, while the refunds it normally receives from drug manufacturers grew only 4.4%. PEIA names 340B as one of the reasons for that gap.

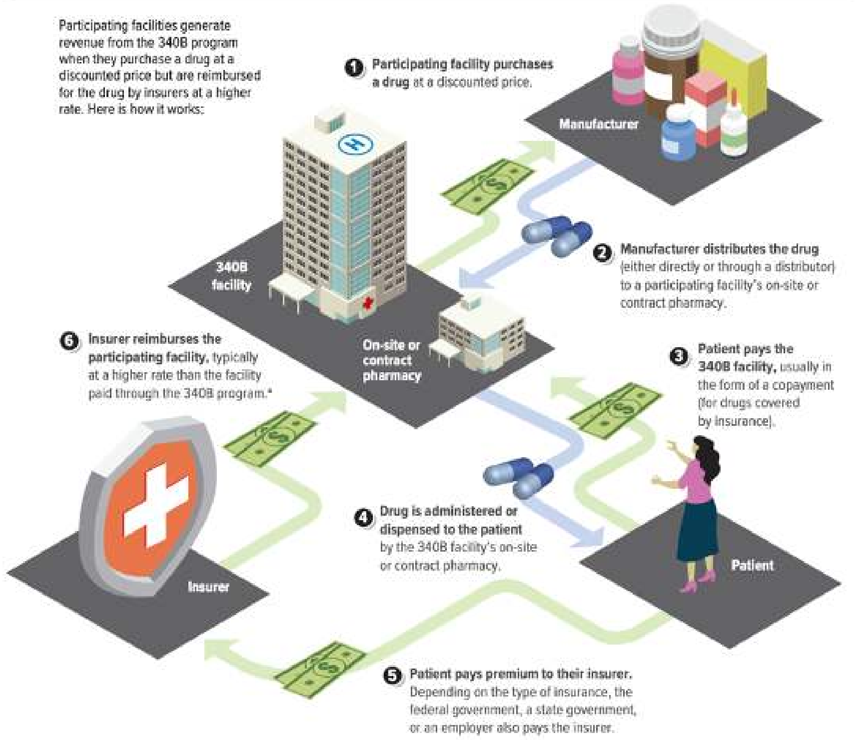
A growing number of states have enacted laws requiring hospitals to report what they receive through 340B and how they use it. Indiana, Idaho, Ohio, Colorado, Maine, Minnesota, Rhode Island, Vermont, and Washington have passed such laws since 2023.

Background: What is 340B?

The 340B Drug Pricing Program was created 1992 through Congress and requires drug manufacturers to sell their drugs at deeply discounted prices to certain hospitals and clinics that serve large numbers of low-income patients. These hospitals and clinics are referred to as "covered entities" under the law.

When a 340B-eligible hospital buys a drug at the discounted price, that hospital can administer or dispense the drug to a patient and bill the patient's insurance at the standard reimbursement rate. The hospital keeps the difference between what it paid for the drug and what it gets reimbursed. Congress's stated purpose for this arrangement was to let safety-net hospitals "stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."

How Drugs and Payments Move Through the 340B System



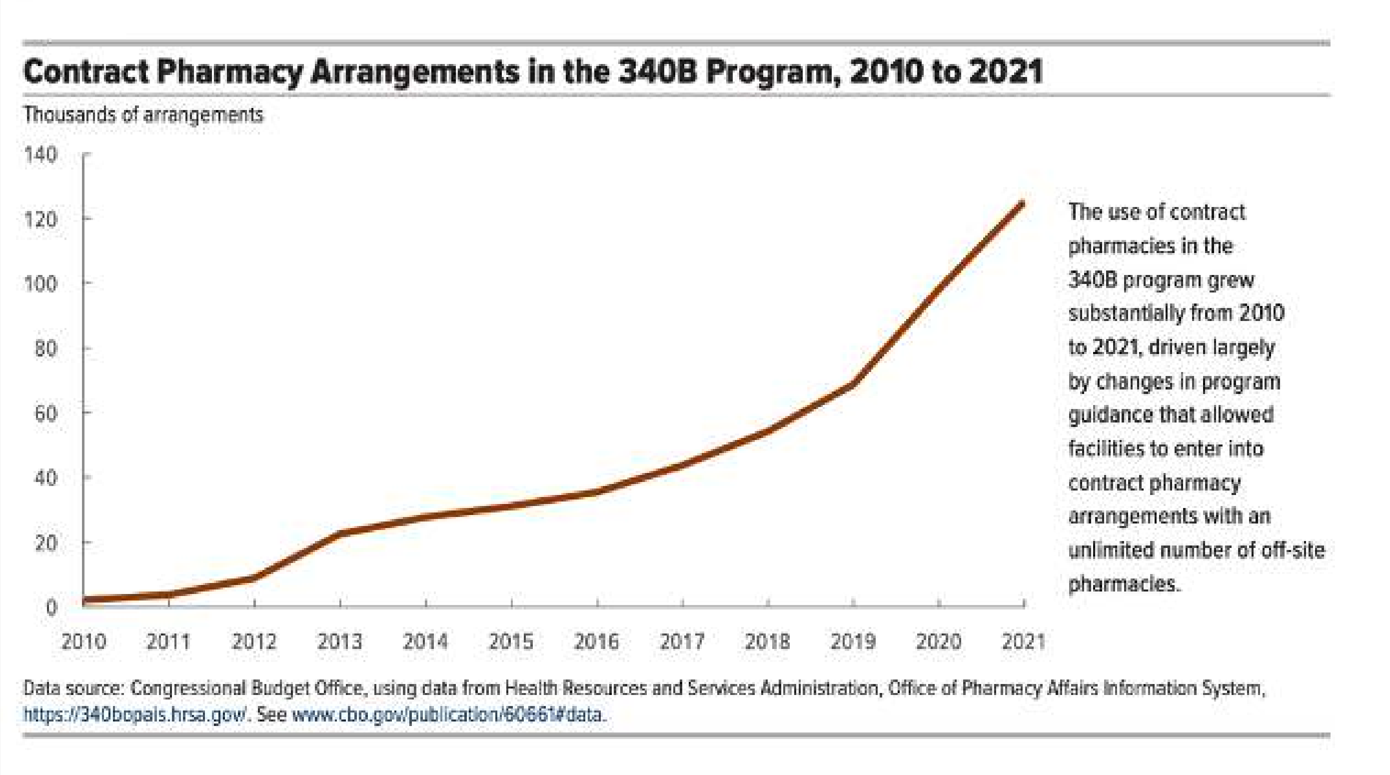
Data source: Congressional Budget Office.

a. Medicaid fee-for-service is an exception. See Box 1 for more information about insurers' reimbursement for drugs purchased through the 340B program.

When the Affordable Care Act was enacted, covered entities were also permitted to contract with pharmacies, or "contract pharmacies." This change led to a significant growth: from one in 1995 to 32,528 in 2024.

The increase in both covered entities and contract pharmacies has naturally increased the number of 340B drug purchase—from $5 billion in 2010 to $81.4 billion in 2024.[1] Meanwhile, the total value of these drugs for list price totaled $147.8 billion.

1 https://www.drugchannels.net/2025/12/340b-hit-81-billion-in-2024-23-why-cms.html.



Source: Congressional Budget Analysis: Growth in the 340B Drug Pricing Program, September 2025

Thirty-seven hospital covered entities participate in 340B in West Virginia today. They fall into three categories:

- **Disproportionate Share Hospitals (DSH):** fourteen of them. These are large hospitals that serve a high share of Medicaid and low-income Medicare patients. Most of West Virginia's 340B revenue is concentrated at these hospitals.
- **Rural Referral Centers:** two of them. These are rural hospitals that meet specific federal criteria.
- **Critical Access Hospitals:** twenty-one of them. These are small rural hospitals (25 beds or fewer) that operate under a different federal payment system.[2]

The program has made assumptions that the savings hospitals capture through 340B will be reinvested in expanded access for low-income patients. Whether that happens cannot be measured. No federal or state authority requires hospitals to report either how much money they receive through 340B or how they spend it. The federal Health Resources and Services Administration, which administers 340B, does not collect this information, and the Internal Revenue Service does not require it on the annual tax returns non-profit hospitals file.

340B Savings in West Virginia

WVU Medicine is the only West Virginia hospital system that has publicly disclosed a 340B savings figure. On a page on its corporate website titled "340B in Action: WVU Hospitals," the system reports approximately $117.3 million in 340B savings at its flagship Morgantown hospital for 2022. The page lists the following categories of uses for those savings: a mobile mammography program (Bonnie's Bus), a diabetes support group, a mobile lung cancer screening program, prescription discharge counseling, replacement funding for a previously state-funded hemophilia program, and Rosenbaum Family House.[3]

2 HRSA Office of Pharmacy Affairs Information System, accessed via published WV 340B hospital inventory.
3 WVU Medicine, "340B Drug Pricing Program" page (wvumedicine.org/340B); "340B in Action: WVU Hospitals" supplemental content on the same site.

The disclosure appears alongside a letter signed by Albert L. Wright Jr. (President and CEO of WVU Health System) and Nicholas J. Barcellona (Senior Vice President and Chief Financial Officer of WVU Health System), arguing against federal proposals to reform the 340B program and characterizing 340B as something West Virginians cannot afford to lose. WVU has not published 340B savings figures for any other year, for any other hospital in its system, or in any format that lets the public see how those savings have changed over time.

To put $117.3 million in context, look at the rest of WVU Hospitals' finances for 2022. That year, the hospital brought in $1.91 billion in total revenue and cleared $128.5 million in operating income after expenses. The 340B savings alone made up about 6% of all revenue—and nearly matched the hospital's entire annual profit. Meanwhile, WVU Hospitals reported just $11.7 million in charity care for patients who couldn't pay, or one dollar of charity care for every ten dollars in 340B revenue.

For the other major hospitals, CAMC, Cabell Huntington, St. Mary's, and Monongalia General, there is no comparable disclosure. We are left in the dark about how much they receive from 340B, or how those funds are used.

CAMC is the closest peer to WVU Medicine in both size and scope. Both reported between $1.4 and $2.5 billion in revenue in 2022 and 2024, and both are large urban hospitals participating in 340B. CAMC reported $12.3 million in charity care in 2022 and $18.3 million in 2024—figures that rival or surpass WVU's, despite CAMC's smaller footprint. Its profit margin was 0.60% in 2022 and 3.33% in 2024. Yet we have no way to know how much CAMC brings in from 340B, or how that stacks up against its charity care.

The Hospital Industry's Position

In April 2026, the American Hospital Association, the West Virginia Hospital Association, and two other hospital industry groups filed a legal brief in a federal appeals court supporting West Virginia and Maryland in a pending 340B case, ***Pharmaceutical Research and Manufacturers of America v. McCuskey.***[4]

The plaintiff, PhRMA, is a trade group that represents brand-name drug manufacturers. The fight centers on a 2024 West Virginia law (Senate Bill 325) passed in response to a national dispute between drug manufacturers and hospitals. Starting around 2020, about 40 drug companies—including most major brand-name manufacturers—began refusing to deliver 340B-discounted drugs to the outside pharmacies that hospitals use to dispense them (called "contract pharmacies"). Hospitals lost revenue.

In response, several states, including West Virginia, passed laws stating that drug manufacturers could not impose those limits if the drugs were going to 340B hospitals in those states, a la SB325. It also included a provision unlike any other state—barring West Virginia from requiring state-level 340B data reporting beyond what the federal government already requires—a provision the hospital lobby had pushed for.

PhRMA sued the state, arguing that the federal 340B law overrides any state requirements in this area. The federal trial court agreed and blocked the enforcement of SB325.

In April 2026, the Fourth Circuit Court of Appeals affirmed that decision. The hospital industry has asked the full appeals court to reconsider, and that request is pending.

SB325's data-reporting prohibition deserves particular attention because it represents a deliberate choice to keep West Virginians in the dark. The law did more than shield hospital contract pharmacy arrangements from drug company resistance; it also blocked the state from requiring any 340B reporting beyond what the federal government asks for—which, as discussed earlier, is nothing. In practice, SB325 cemented the federal accountability gap into West Virginia law. Hospitals could keep collecting substantial 340B revenue, spend it however they wished, and decline to report any of it. The state would not be permitted to even ask.

4 Brief of American Hospital Association, West Virginia Hospital Association, 340B Health, and American Society of Health-System Pharmacists as Amici Curiae in Support of Defendants-Appellants and En Banc Review, PhRMA v. McCuskey, No. 25-1054 (4th Cir.), filed April 17, 2026.

The West Virginia Hospital Association's 2024 Legislative Summary listed SB325 as a high-priority bill. In 2025, WVHA explicitly opposed SB675—requiring participants in the federal 340B Drug Pricing Program to report certain data—and their broader 2025 priorities explicitly included "opposing attempts to modify/repeal SB325 from the 2024 Session."

Free markets rely on information flowing to buyers, customers, and the public. SB325 was a calculated move to suppress that information, at the urging of an industry that profits from keeping the public in the dark. Regardless of where one stands on the contract pharmacy dispute, the data-reporting ban is a separate and troubling issue, one that no other state seems to have adopted. The federal court did not strike down the reporting ban for reasons of accountability; it did so because SB325 as a whole likely conflicts with federal law. The upshot is the same: West Virginia is now free to require public reporting on 340B if lawmakers choose. The hospital lobby's preferred world where neither the federal government nor the state demands disclosure is no longer permitted to remain law.

The joint brief to reconsider, from the Hospital Associations in support of the law, makes several claims worth examining.

First, the brief states that "the contract pharmacy policies have caused a whopping $39 million in annual losses to WVU." This refers to drug manufacturers' decisions to limit the number of outside pharmacies a 340B-participating hospital can use to dispense 340B drugs. The brief does not specify whether "WVU" means just the flagship hospital in Morgantown (for which the $117.3 million 2022 figure exists) or the entire WVU Health System. Either way, the $39 million figure is consistent with the idea that 340B revenue at WVU is substantial and likely larger than the one 2022 number the system has publicly disclosed.

Second, the brief asserts that "340B providers typically operate with razor-thin (and often negative) margins." For WVU Hospitals specifically, this is not supported by the hospital's own federal tax filings. WVU Hospitals reported an operating margin of 6.74% in 2022 and 3.83% in 2024, meaningful profit margins by hospital industry standards. The "razor-thin margins" framing is more accurate at CAMC in 2022 (0.60%), but not at CAMC in 2024 (3.33%), or at WVU in either year.

Third, the brief includes specific descriptions of how West Virginia hospitals use 340B savings. For example, that Cabell Huntington Hospital uses 340B revenue for substance-use treatment programs. These descriptions appear in litigation filings. But note, it took a legal battle for a sliver of transparency they fight so hard against; these numbers are not disclosed anywhere West Virginians can find them as part of routine reporting.

Free-Market Accountability

Calling for state-level 340B reporting is not about inviting more government interference in the hospital market. It is the opposite. It is about giving the public just enough information to balance the significant protections these hospitals already receive from state and federal government.

West Virginia's largest non-profit hospital systems benefit from three forms of protection from normal market competition:

1. **Tax exemption.** Federal, state, and local. These hospitals pay no income tax. They pay no property tax. They pay no sales tax on most purchases. Their donors get tax deductions for contributions. This is, in effect, a permanent subsidy not available to for-profit competitors.
2. **Certificate of Need.** West Virginia is one of about 35 states that require hospitals to get government approval before they can open new facilities or offer certain new services. The stated purpose is to prevent the duplication of facilities in rural markets. The practical effect is to shield existing hospitals from competition by new ones.
3. **The 340B Drug Pricing Program.** This gives participating hospitals discounts on prescription drugs that non-participating hospitals cannot access.

Each protection has a justification. Tax exemptions reward hospitals for providing free care to patients who cannot pay. The Certificate of Need is supposed to prevent rural markets from being overbuilt. 340B is supposed to help safety-net hospitals stretch their resources. Any one of these may be defensible on its own merits.

Together, these protections insulate West Virginia's largest hospital systems from the kind of competition that usually keeps businesses honest on cost, quality, and service. When government policy blocks competition, the only real substitute for market accountability is public reporting—enough information for lawmakers, journalists, and citizens to judge whether hospitals are delivering the public benefits that justify all these advantages.

West Virginia currently offers all three protections yet requires no public reporting on 340B. That is not a free-market stance. A true free-market accountability approach would remove these protections and let competition do the work.

The Cost to West Virginia's Employee Program

The question is not only what hospitals do with 340B money. It is also what the program costs other public institutions in West Virginia. The Public Employees Insurance Agency, or PEIA, covers more than 200,000 West Virginians including state workers, teachers, retirees, and their families. PEIA has identified 340B as a real driver of rising drug costs for the plan.

It is important to be clear about what PEIA is, because arguments from the hospital industry often imply that PEIA is a low-paying government program. That is not what PEIA is. Under West Virginia Code § 5-16-5(c)(1), PEIA is required by state law to pay healthcare providers at least 110% of the rate Medicare pays for the same service, with no cap on what providers can charge. PEIA pays hospitals at above-Medicare rates by law. The 340B program then extracts additional revenue from those same prescriptions through a mechanism that imposes a cost back on the state plan.

Here is how that mechanism works: when a drug company sells a prescription drug, the price the pharmacy pays at the counter is not the price the insurance plan ultimately pays. After a prescription is filled, the drug company typically remits payment to the insurance plan or the plan's prescription benefits manager. That payment, called a "rebate," reduces the plan's actual drug payment. Whatever one's broader views about the rebate system itself, which is a feature of the existing federal drug pricing structure, with its own well-documented distortions, within the system as it currently operates, manufacturer rebates are part of how insurance plans like PEIA manage their net drug costs. The 340B program changes this.

When a 340B-participating hospital buys a drug, the drug company already gives the hospital a steep discount up front. Because the drug company has already cut its price for that specific prescription, it does not send the after-the-fact payment to the insurance plan. So, the plan loses out on a refund it would have gotten otherwise. But the cost difference does not disappear from the system; it shifts to the insurance plan.

For PEIA, the result is documented in the report to the West Virginia Legislature. In PEIA's December 2024 report to the Joint Committee on Government and Finance, PEIA reports that its total drug costs grew from $332.2 million in fiscal year 2023 to $413.4 million in fiscal year 2024. That is an increase of $81.2 million, or 24.4%, in a single year. The total refunds PEIA received from drug companies grew only 4.4% over the same period. PEIA's report lists 340B as one of the factors driving the gap between rising drug costs and the refunds that normally offset them. On a per-member basis, PEIA's net drug cost rose 44.2%, from about $102 per member per month to about $147 per member per month, in a single year.[5]

PEIA's report also includes a worked example showing how the cost shift works at the level of a single prescription. For a hypothetical $1,000 drug:

- **Filled through a regular pharmacy:** PEIA pays the pharmacy about $960. The drug company sends PEIA a refund of about $600 afterward. PEIA's actual cost is about $335.
- **Filled through a 340B-participating hospital:** PEIA still pays the hospital about $960. But the drug company sends no refund, because it already discounted the drug to the hospital up front. PEIA's actual cost is about $935.

5 Public Employees Insurance Agency, West Virginia Senate Bill 453 (2024 Session) Report, prepared by Madalena Consulting, LLC, with support from 3 Axis Advisors, LLC, and Nixon Peabody LLP, December 30, 2024 (submitted to the West Virginia Legislature's Joint Committee on Government and Finance pursuant to W. Va. Code § 5-16-9), at pp. 8-9.

	340B	Non 340B
Prescription AMP Price	$ 1,000.00	$ 1,000.00
340B Discount (23.1%)	$ 231.00	$ -
Pharmacy Net Price	$ 769.00	$ 1,000.00
PBM Contractual Rate	$ 960.00	$ 960.00
Pharmacy Profit on Contract Rate	$ 191.00	$ (40.00)
Rebate (60% of WAC/AMP)	$ -	$ 600.00
PEIA Net Cost	$ 935.00	$ 335.00

The difference per prescription flows to the 340B-participating hospital as program revenue. The drug company's discount, intended by Congress to help safety-net hospitals serve indigent patients, instead substitutes for the refund that would have lowered the cost of the same drug to West Virginia's public employees, teachers, and retirees.[6]

PEIA managed to negotiate a temporary cap on this cost for 2025. But the underlying problem remains. The 340B program has been expanding nationally by 16 to 24% a year for the past decade.[7]

The December 2024 report states:

> *"Historically, the typical 340B healthcare providers were Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), and Critical Access Hospitals (CAH). As the program has expanded to include other eligible healthcare provider types (e.g., hospitals that participate in the Disproportionate Share Hospital (DSH) program), the negative financial effect on PEIA has also grown…While PEIA has been successful in negotiating a cap on 340B rebate reductions for SFY 2025, other methods of managing PEIA's disadvantage should be considered in the long run. 340B exclusions are the largest in terms of volume for both discount and minimum rebate guarantees."*

This is where the accountability question becomes more realized. Hospitals collect 340B revenue. PEIA—and by extension, every public employee, teacher, and retiree paying premiums—covers the cost of lost rebates. Whether hospitals use that money to help more patients is anyone's guess, because no rule requires them to say.

West Virginians are footing the bill on both ends. They deserve to know where their money is going.

The Legal Landscape

In April 2026, a federal appeals court blocked West Virginia from enforcing Senate Bill 325, a two-part law. The first part barred drug companies from limiting the number of outside pharmacies 340B hospitals could use. The second part barred West Virginia from requiring any state-level 340B data reporting beyond what the federal government requires.[8] The court held that both parts of the law are likely blocked by federal law because they impose state-level requirements in an area governed by the federal 340B program.

6 *Id*. at p. 22 (Figure 11 — 340B Example illustrating PEIA's per-prescription cost disadvantage).
7 Congressional Budget Office, Growth in the 340B Drug Pricing Program (September 2025).
8 *Pharmaceutical Research and Manufacturers of America v. McCuskey,* 171 F.4th 675 (4th Cir. 2026).

The court's ruling addressed state laws that try to regulate what drug companies must do. It did not address state laws that require hospitals to report what they receive. These are different things in the eyes of the law. The first kind of law tries to change how a federal program operates. The second kind requires the state's own tax-exempt institutions to disclose information about themselves—something states have long-established authority to do. Indiana, Minnesota, Idaho, Ohio, Colorado, Maine, Rhode Island, Vermont, and Washington have all enacted laws requiring 340B hospitals to report. None has been struck down on federal preemption grounds.

The practical effect of the federal court's ruling, then, is twofold. First, it leaves drug manufacturers free to continue limiting contract pharmacy arrangements (the issue the hospital industry was fighting about). Second, it removes West Virginia's statutory bar on 340B reporting. The state is free to enact transparency legislation if it chooses to.

Recommendation

West Virginia should pass a state-level 340B reporting law. Other states have already done this since 2023.

Minnesota's law, enacted in 2023, covers all 340B covered entities, including urban and rural hospitals. Non-compliance penalties are not specified in the statute, but enforcement is handled by the state health department. The law emphasizes payer-specific reimbursements alongside savings use, with detailed claims data.

Under Minnesota's law[9], hospitals must report each year:

- How much they paid for 340B drugs (the discounted price)
- How much they were reimbursed by each payer (Medicare, Medicaid, commercial insurers) for those drugs
- Total claims volume and payments to contract pharmacies
- How they used the 340B savings, including charity care, uncompensated care, and community benefits

Idaho's law, signed in 2025, applies to all 340B entities. Hospitals face civil penalties up to $10,000 per violation for non-filing. It stands out for granular claims-level reporting tied to patient benefits.

Under Idaho's law[10], hospitals must report each year:

- How much they paid for 340B drugs (the discounted price)
- How much they were reimbursed by insurance for those drugs (broken down by payer)
- Detailed claims data, including volume, contract pharmacy fees, and diversion prevention
- How they used the 340B revenue, with specific allocations to charity care, subsidies for low-income patients, and operational costs

Indiana's law, signed in 2025, covers urban hospitals, children's hospitals, and small rural hospitals. Hospitals that don't file face a $1,000-per-day fine. The law also requires hospitals to report not just what they get, but how they spend it, with a close look at charity care.

Under Indiana's law[11], hospitals must report each year:

- How much they paid for 340B drugs (the discounted price)
- How much they were reimbursed by insurance for those drugs (the standard price)
- What they paid to outside pharmacies that dispense 340B drugs on their behalf
- How they used the 340B revenue, including how much went to charity care and other community benefit

9 Minnesota Statutes § 62J.461 (enacted 2023; amended 2024).
10 Idaho Code § 56-278 (enacted via House Bill 136, 2025).
11 Indiana Code § 16-21-48 (enacted via Senate Enrolled Act 118 / Public Law 188, 2025).

West Virginia's version of this law should include:

1. Apply to all covered entities in West Virginia, plus any outside pharmacies that dispense 340B drugs to West Virginia patients on behalf of a covered entity.
2. Require covered entities to disclose how much they paid for 340B drugs, the discounted price, and how much they were reimbursed for those drugs, broken down by payer: Medicaid, Medicare, PEIA, and commercial.
3. Require covered entities to disclose what they paid to contract pharmacies that dispense 340B drugs on their behalf with claims data including volume, contract pharmacy fees, and diversion prevention.
4. Require covered entities to report what they spend 340B money on, not just what they receive, including charity care, community benefit, and operational cost.
5. Make the reports public, organized by individual covered entity, with consequences for those that fail to file, including a per-day fine.

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