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May 13, 2025

Representative Alyssa Black, Chair
Vermont House Committee on Health Care
155 State Street
Montpelier, VT 05602

RE: Office of the Health Care Advocate Testimony regarding H.266 White Bagging Prohibition Repeal

Dear Chair Black and Members of the Committee:

Thank you for the opportunity to provide testimony regarding changes to H.266 made in the Senate and specifically the addition of a temporary repeal of the prohibition on white bagging.

First, it is not surprising to me that we are here today talking about this particular bucket of drug spending: physician administered drugs in an outpatient setting. If H.266 becomes law and we all receive the reporting the bill calls for, I think we will see that the largest source of 340B revenue for Vermont hospitals is far and away these outpatient administered drugs.

On the issue of white bagging in particular: We have heard that white bagging risks patient safety. We have also heard that white bagging causes inconvenience for providers and for patients. Do patients care about safety? Obviously, yes. Do patients care about convenience, particularly when they are sick with a very serious illness? Again, yes.

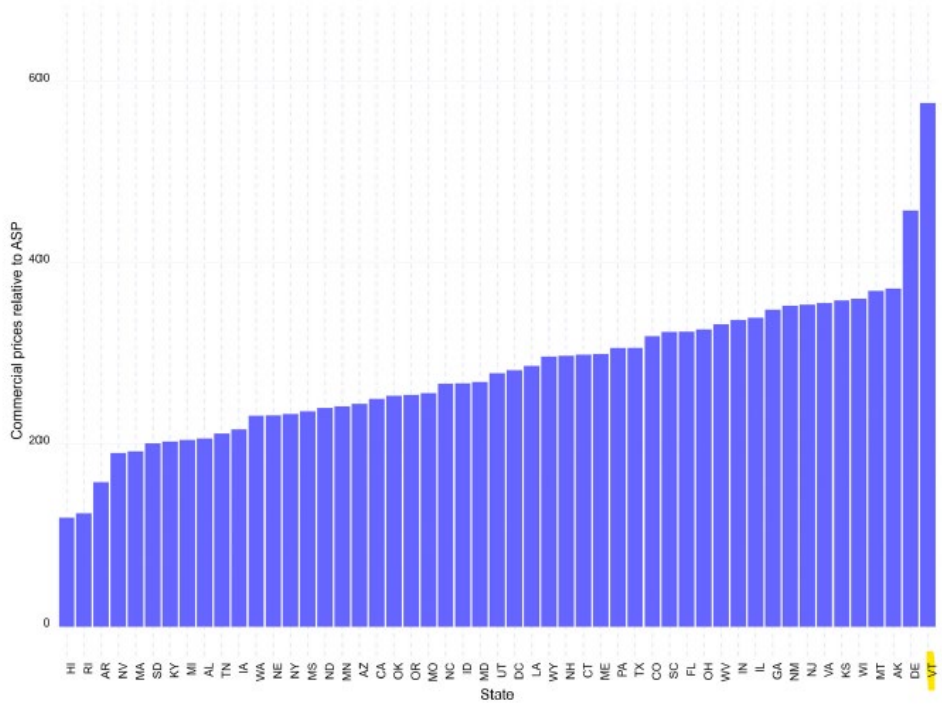
Safety and convenience are not something just to shrug off. But patients are also concerned about money. They are concerned about their own personal finances. And, increasingly, they are concerned about the financial stability of the system as a whole. They want to know that they are not vastly overpaying for their treatments and that those treatments are not bankrupting the system.

The prohibition on white bagging, which means that a health plan cannot require a patient to obtain a physician administered drug from a preferred pharmacy,

what that has done, in effect, is to give hospitals a green light to charge whatever they can for these drugs, whatever the market will bear. The hospitals effectively have no competition in this space and no incentive to lower prices.

We can see that quite clearly in Vermont.

Figure 4.7. State-Level Hospital-Administered Commercial Drug Prices Relative to ASP, 2020–2022



Source: Christopher M. Whaley, et al., *Prices Paid to Hospitals by Private Health Plans: Finding from Round 5.1 of an Employer-Led Transparency Initiative* (2024) at 22.

You may have seen this very impressive chart that has been making the rounds from a 2024 RAND report, a bar chart comparing all 50 states' hospital administered drug prices from cheapest on the left to most expensive on the right—with Vermont the right-most bar, the most expensive, and not by a little, but by a lot. The chart shows that hospital administered drug prices relative to ASP in Vermont are at nearly 600%, or nearly 6x the average sales price.

ASP is the average sales price. It is a pricing benchmark intended to reflect the average price at which a drug is sold to providers, like hospitals and outpatient clinics, inclusive of rebates, discounts and other pricing adjustments. Notably, it is not the 340B price, which is likely much lower. CMS uses ASP to set reimbursement for Medicare Part B drugs. Medicare reimburses outpatient facilities at ASP plus 6%, plus costs for administering the drug. The graph from

RAND shows Vermont hospitals being reimbursed for outpatient administered drugs, on *average*, at ASP plus nearly 600%.

A patient is likely to perceive this fact only one way—they are vastly overpaying for their treatment. Imagine being on a high-deductible health plan, this means, for a drug that costs $1,000 ASP, you could pay nearly $6,000. For a person who may be sick with cancer, rheumatoid arthritis, multiple sclerosis, or Crohn's, paying $6,000 for something that costs $1,000, is the kind of thing that could make you even sicker.

And it should not be that way. Every other state is paying less than us; most states are paying much less than us.

The Senate Health and Welfare Committee has added a temporary repeal of the prohibition on white bagging to H.266 as a way to deal with this issue. The HCA thinks there is some merit to this approach. Ending the hospitals' monopoly on acquiring outpatient administered drugs for patients could cause hospitals to lower their prices. Or patients could benefit from lower prices negotiated by their health plan's PBM. Or at least it is worth trying to see whether allowing white bagging puts downward pressure on administered drug prices.

Another approach could be to simply set a cap on administered drug prices at a certain percentage of ASP—for example, put in statute, hospitals shall not seek reimbursement for administered drugs that exceeds 120% of ASP, or 200% of ASP—or whatever you decide. It seems likely a reimbursement cap would be more likely to have an immediate, system-wide impact. Patients would almost certainly benefit from reduced prices, too.

In conclusion, the HCA's position would be yes, we think something needs to be done to address the issue of having the highest administered drug prices in the nation. Whether that be a white bagging repeal or a reimbursement cap, we would probably prefer the reimbursement cap, but of course, we look forward to your discussion and to being of assistance if you need any further information from us. Thank you for your consideration.

Sincerely,

/s/ Charles Becker
Staff Attorney
Office of the Health Care Advocate