Increasing Accountability: Policy Pathways to Lower Prescription Drug Prices in Vermont

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Summary

The goal of this paper is to clarify the supply chain stakeholders responsible for the precipitous increase in prescription drug prices and identify the ways in which the state of Vermont can endeavor to mitigate excessive supply chain markups through legislation. Pharmacy Benefit Managers (PBMs), hospitals, and other payers are receiving an increasing proportion of total expenditures for brand-name medicines. In 2023, 25% of all brand-name drug spending went directly to PBMs, insurers and other supply chain entities. 340B provider markups also accounted for 10% of all brand-name drug expenditures (Blalock et. al, 2025). We have chosen to focus specifically on the role of PBMs, and 340B program hospital participants, because a very large proportion of rising drug expenditures can be attributed specifically to the aggressive markup tactics of these groups. We are also interested in exploring the effectiveness of reference-based pricing as a possible solution to mitigate these price discrepancies. Through in-depth interviews with expert stakeholders and extensive literature reviews, we have identified supply chain markups from these same groups (i.e., PBMs, 340B program covered entities and payers) occurring in the state of Vermont.

Key findings from this report include:

- Limited oversight and lack of transparency allows PBMs to engage in "spread pricing", in which the PBM reimburses a dispensing pharmacy for less than the amount that they charged the pharmacy and pocketing the difference. PBMs also take advantage of the 340B Drug Pricing Program by misappropriating savings meant for eligible patients who receive treatments at covered entities, thus earning profit margins in the 340B program that are up to four times higher than in the commercial market
- Discounted drug prices and drug price markups by hospitals participating in the federal assistance program, 340B, generate a surplus, known as 340B revenue. Blue Cross Blue Shield of Vermont (BCBSVT) reports that Vermont hospital drug markups for high-cost specialty drugs can be upwards of 1410% their Average Sales Price (ASP). Greater reimbursement rates may force insurers to change their insurance plan by increasing premiums and/or cost-sharing in order to cover these rising costs. Thereby, reducing affordability and access for individuals in need of prescription drug medication.
- Reference-based pricing (RBP) is a cost-containment strategy that sets a maximum allowable payment for specific health care services, based on comparable prices. Unlike other high-income countries, the U.S. lacks transparency in net manufacturer prices, making it difficult to implement RBP tied to these prices. As a result, states often enact RBP models based on multiple Medicare rates. However, in rural areas like Vermont, constrained provider choice and tight margins pose challenges. Adopting RBP in Vermont may require hybrid pricing models, rural hospital exemptions, and state-specific price transparency tools.

We are proposing three policies that target:

- Requiring PBMs to report how they reimburse 340B claims;
- Capping Physician-Administered Drug Price Markups at 120% of ASP; and
- Reference-based pricing models tailored for the rural setting in Vermont

Introduction

Overview of the Problem

In 2022, patients in the United States spent $603 billion on prescription drugs (Mulcahy et al., 2024). To put this number in perspective, this represents a 91% increase in prescription drug expenditures in the past two decades. Further, the Centers for Medicare and Medicaid Services predicts that spending on prescription drugs will be the fastest growing category of health spending in the next decade ("Prescription Drug Spending", 2018). In a country that already spends more per capita on healthcare than any other nation in the world, it is particularly salient that our prescription drug prices are the fastest growing category of healthcare expenditures. Despite prescription drug expenditures being a lesser percentage of total health expenditures, they are placing growing pressure on state Medicaid programs, the federal deficit, and private insurance premiums. Namely, state Medicaid programs are grappling with budgetary constraints, the federal government faces mounting pressure from Medicare Part D expenditures, and private insurers are shifting rising costs to consumers through higher premiums and out-of-pocket expenses. This has direct implications for patient access and health outcomes. Specifically, nearly 30% of Americans are falling behind on filling their prescriptions because of these escalating expenses (Feldstein, 2019).

In the state of Vermont, legislators have expressed interest in developing new policies to mitigate the problem of increasing prescription drug prices. In 2024, the Vermont Senate passed Act 134, which "tasks the Green Mountain Care Board with creating a framework and methodology for implementing a program to regulate the cost of prescription drugs for Vermont consumers and Vermont's health care system" ("Act 134", 2025, p.6).

The Task at Hand

As Middlebury students in Professor Holmes' Healthcare Economics prescription drug pricing group, we have been tasked with identifying the root causes of unconscionably high prescription drug prices in Vermont and proposing feasible and actionable steps that the Vermont legislature can take to address this problem.

Our Process

Collectively, we have spent around 70 hours reading the existing literature, meeting with stakeholders, writing literature reviews and preparing this executive summary. We first were connected with Kathryn O'Neill, Director of Prescription Drug Pricing and Noah Montemarano, Health Policy Analyst, assigned by the Green Mountain Care Board (Act 134) to research and propose policies aimed at reducing prescription drug spending in the state of Vermont. From there, we were directed to speak with the Medical Director, Dr. Tom Weigel and the Pharmacy Director, Nancy Hogue from Blue Cross Blue Shield of Vermont where we discussed the effects of prescription drug costs on commercial insurance and potential policies that could reduce the drug cost burden on private insurers in Vermont. We also spoke with two Vermont Legal Aid Health Care Advocates, Mike Fisher and Charles Becker. In describing their roles as Health Care Advocates, Mike and Charles provided anecdotal insight into the ways in which high prescription drug costs can have devastating material effects on the lives of individual Vermonters.

With direction from stakeholders, we conducted our own individual literature reviews that explored how PBM practices, increasing utilization of high-cost, specialty drugs, and opaque drug negotiations contribute to the rising costs of prescription drugs in Vermont. We considered federal and state policies that have increased oversight of PBMs, developed new payment models based on health outcomes, and enacted greater price transparency regulations. The literature referenced can be found in the Appendix below.

After our initial research phase, we took steps to consolidate our individual findings and establish a clear focus for our policy proposals. We identified our root cause of interest—a lack of transparency in the pharmaceutical supply chain—and created initial policy proposals that would address the ways in which different actors throughout the supply chain take advantage of this lack of transparency by marking up drug prices. We shared these initial ideas with our expert stakeholders (mentioned above). Blue Cross Blue Shield Medical Directors Tom Weigel and Nancy Hogue advised us to consider approaches that address the inflated billing rates tied to the 340B Drug Pricing Program, which acts as the impetus for our policy proposal.

Aim of this Proposal

The following section will explore how the lack of transparency around PBM practices, and hospital prices for physician-administered drug markups can further drive the cost of prescription drugs, creating affordability challenges and worsening health outcomes for patients. It will examine reference-based pricing as a potential policy approach to these inefficiencies. Moreover, this section will further consider the limitations of current policies that increase transparency and the potential need for increased regulations to control drug costs, in particular, high-cost, specialty drugs.

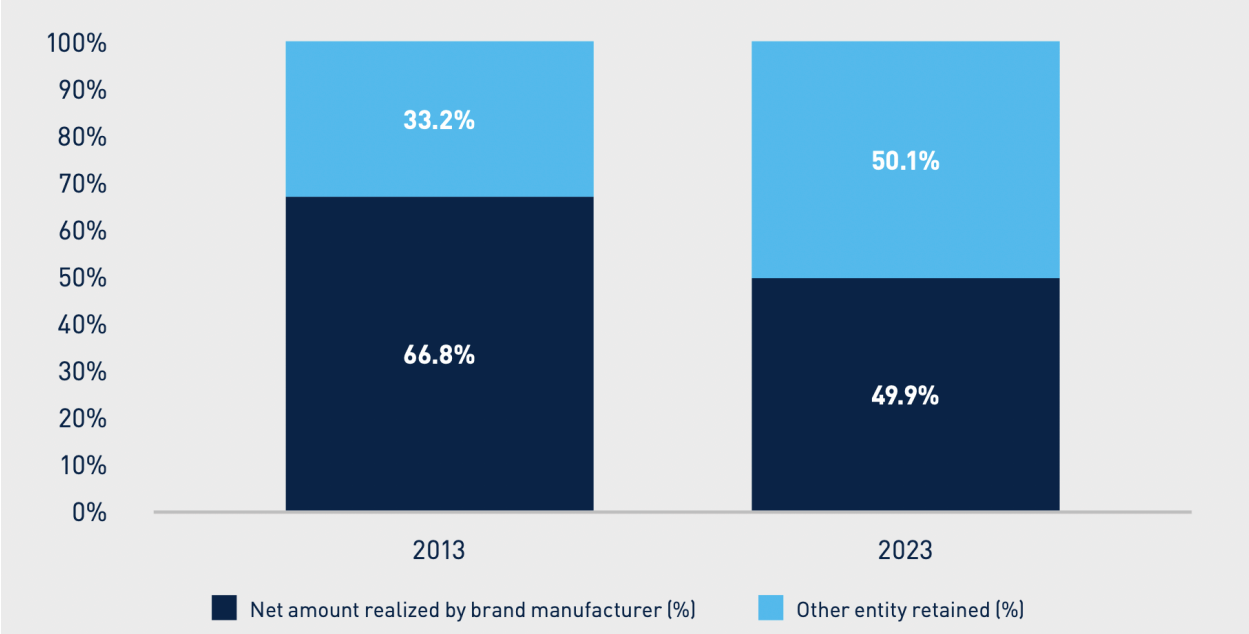
Background

Inflated Drug Costs: The Role of PBMs

The net prices paid for drugs in the US are driven primarily by manufacturer costs and those of health plans and Pharmacy Benefit Managers, or PBMs. The uniquely high drug costs faced by US patients are a reflection of the highly complex set of interactions between these various entities. Further, interactions between actors in the pharmaceutical supply chain are both fragmented and opaque which allows for price markups to occur, the extent of which is largely unknown to the public and policymakers (Mulcahy et al., 2024).

PBMs have a substantial role in determining the price consumers pay for prescription drugs. They act as intermediaries between manufacturers and pharmacies and determine the formularies for health plans, which are the lists of drugs that are covered by a certain plan. While PBMs claim to fulfill a necessary role in the medical supply chain, the PBM structure has also been criticized for its lack of transparency - prices paid by PBMs are "generally not known by policymakers and researchers because rebates from manufacturers are considered trade secrets" (Mulcahy et al., 2024, p.3). Limited oversight allows PBMs to engage in a practice known as "spread pricing", in which the PBM reimburses a dispensing pharmacy for less than the amount that they charged a patient and pocketing the difference ("Act 127", 2024). Further, the evolution of the 340B Drug Pricing Program has exacerbated the ability of PBM-controlled pharmacies to siphon away savings meant for patients who receive care from covered entities. The 340B Drug Pricing program was passed in 1992 by congress in order to support "safety net providers" who serve low income and underinsured patients (Children's Hospital Association). In the state of Vermont, 14 out of a total of 15 hospitals are 340B covered entities. It is estimated that in 2023, PBM-controlled pharmacies redirected over $2.58 billion in 340B savings away from eligible patients for their own profit. This represents a 3X increase in the PBM share of the 340B margin in the decade between 2013 and 2023 (Blalock et. al, 2025).

Figure 1: Total Gross Expenditures for Brand Medicines Received by Manufacturers and Other Entities



PBMs and other entities in the medical supply chain are taking a growing share of drug expenditures.
Blalock, E., Ferritto, M., & Taylor, J. "The Pharmaceutical Supply Chain, 2013-2023." *Berkeley Research Group*. (2025). https://cdn.aglty.io/phrma/global/blog/import/pdfs/PhRMA_Supply-Chain-2013-2023_White-Paper_V484.pdf

Further, because PBMs determine health plan formularies, they sometimes choose to substitute out cheaper, cost-effective drugs for more expensive alternatives that bring in higher profits (3 Axis Advisors, 2023). The state of Vermont is currently suing the PBM conglomerates CVS Caremark and Express Scripts for increasing drug prices for their own profit. These two PBMs combined control over 95% of the drug transactions in Vermont (State of Vermont v. Evernorth Inc., et al., 2024).

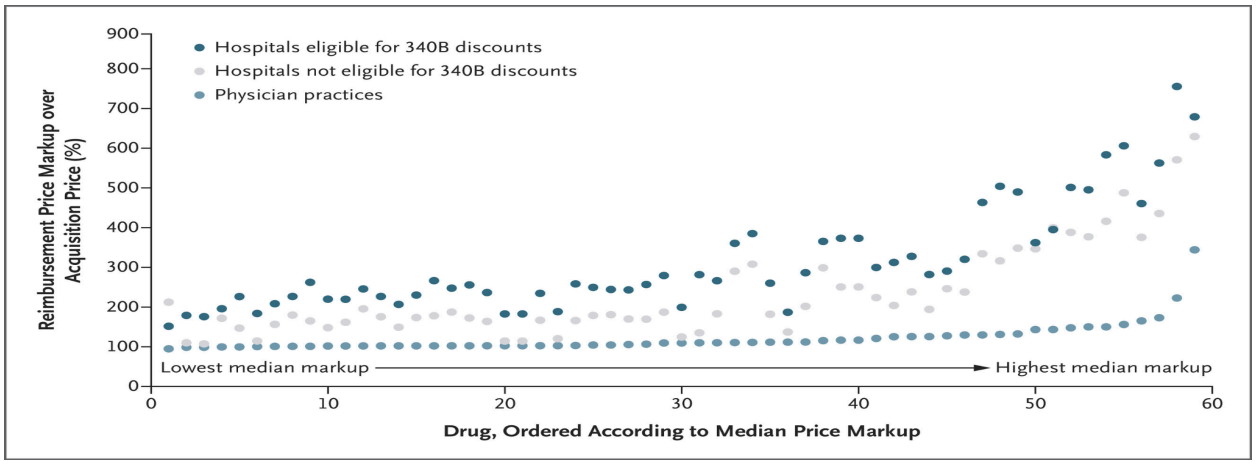
In 2024, the Vermont Senate passed Act 127, a first attempt at regulating the market power of PBMs. Act 127 puts the Department of Financial Regulation in charge of PBM oversight. PBMs operating in Vermont are now required to register and receive a license from the state. Operating PBMs will now be required to submit their data into the All Payer Claims Database, which will be used by the Department of Financial Regulation to monitor and regulate their activity. Specifically, this data is expected to be useful in spotting "spread pricing" practices, which the act also prohibits ("Act 127", 2024). The implementation process of this law is still underway, and therefore the extent of its effectiveness in reducing Vermont's drug costs has yet to be revealed.

340B Drug Pricing Program and Rising Costs for Hospital-Administered Drugs

340B is a federal program that requires drug manufacturers to offer discounts for hospital-administered prescription drugs sold to hospitals that mainly serve low-income patients (Knox et al., 2023; Robinson et al., 2024). In Vermont, 14 out of the 15 hospitals participate in the 340B program ("A Closer Look at 340B"). Hospitals participating in 340B can charge higher prices than the acquisition price of the drug, generating a surplus known as 340B revenue (Knox et al., 2023). This surplus can support other hospital services and infrastructure that support low-income individuals (Knox et al., 2023). But, as reported in the

New England Journal of Medicine, estimated average drug markups using the Average Sales Price estimates from the Centers for Medicare and Medicaid Services, found that hospitals eligible for 340B are more likely to have higher markups than in hospitals not eligible (Robinson et al., 2024).

Figure 2: Comparison of Reimbursement Price Markup over Acquisition Price (%) for Eligible and Not Eligible Hospitals for 340B Discounts



Robinson, James, Christopher Whaley, and Sanket Dhruva. 2024. "Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance." *The New England Journal of Medicine* 390 (4). https://doi.org/10.1056/NEJMsa2306609.

Moreover, recent findings have suggested that the 340B program has shifted away from its original goal to support the financially vulnerable as there is more of a financial incentive for hospitals to serve insured patients, where hospitals will generate greater revenues from reimbursements (Conti and Bach, 2024). Further, the current 340B program does not require a hospital to report how funding is being utilized to serve the uninsured (Conti and Bach, 2024). Thus, there is uncertainty in exactly how 340B revenue is being used.

As a result of high cost claims, insurers may have to change their insurance plan by increasing premiums and/or cost-sharing in order to cover these rising costs (Act 193; BCBSVT). High premiums reduce affordability and access for individuals in need of prescription drug medication. Well-documented across the literature are the negative health outcomes that can result from cost-related medication non-adherence (Blanchard et al., 2013; Nekui et al., 2022). Medication non-adherence includes practices like skipping doses or not filling prescriptions usually due to the high costs that a patient has to pay for these prescription drugs (Nekui et al., 2022). In a study published by the Annals of Emergency Medicine (2013), cost-related medication non-adherence practices were associated with greater utilization of emergency room services, which can further drive costs of healthcare (Blanchard et al., 2013). Therefore, the high markups for physician-administered drugs can reduce healthcare affordability for many patients and increase the risk of negative health outcomes.

Vermont hospital-administered drug price markups are much steeper than hospitals across the country (Whaley et al., 2024). Legislation is currently being discussed in both the Vermont House of Representatives and the Senate that aims to increase reporting transparency around the 340B Drug Pricing Program. Bill H.266, "an act relating to 340B prescription drug pricing program," is one such bill that was

passed by the Vermont House of Representatives on March 18, 2025. If it takes effect, it will prohibit discrimination of 340B covered entities by drug manufacturers and require 340B participating hospitals to submit annual reports with information like: acquisition costs of drugs that are part of the 340B program, 340B program expenses, and a description of how potential surplus is used (H.266 18 V.S.A. chapter 91, subchapter 6).

Minnesota enacted a similar price transparency law for 340B covered entities in 2023 (Nikpay et al., 2025). Last fall 2024, the Minnesota Department of Health released a report detailing the outcomes of this required price transparency law (Minnesota Department of Health, 2024). The report indicated that $630 million was reported as 340B revenue in 2023. Of the reported 340B revenue, 70% was contributed by only 17 drug families, indicating that high-cost, specialty drugs are the major contributors to hospital profit and high reimbursement rates for commercial insurers. Moreover, the report states that the $630 million in revenue is an underestimate and may only account for half of the actual revenue generated by 340B prescription drugs. Difficulty in collecting data, particularly for office-administered drugs, resulted in this underestimate (Minnesota Department of Health, 2024). While Minnesota's transparency law did establish regulations for hospital transparency around 340B funding, it also highlighted some of the barriers that states who aim to enact a similar law could face, particularly in the limitations with data collection. This finding is consistent with other drug pricing transparency laws which have been found to not be effective at reducing specialty drug costs (Act 134; Taylor et al., 2024). Therefore, Vermont should consider expanding their proposed bill to enact stronger restrictions on hospital-administered drug markups by hospitals.

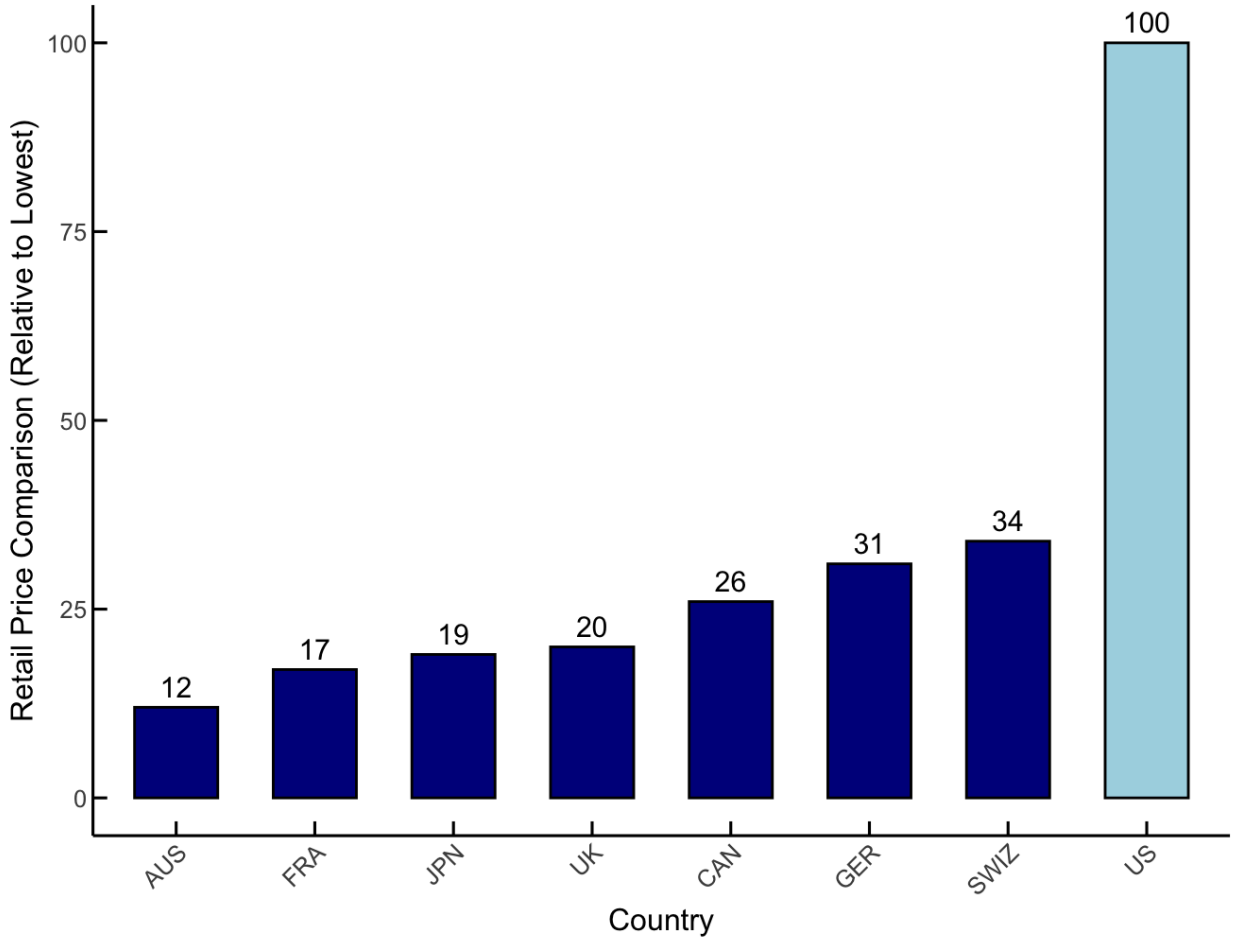
Tailoring a Reference-Based Pricing Model for Vermont

Compared to other high-income countries, the United States is an outlier in terms of its exceptionally high prescription drug prices. A report from The Commonwealth Fund found that "for a basket of the 10 selected drugs in 2021, the price in the U.S. is three to eight times the price in every comparison country," (Gumas et al., 2024) (Figure 3). Reference-Based Pricing (RBP) in the US is an emerging cost-containment strategy that looks to reduce this exorbitant gap, by setting maximum allowed prices typically based Medicare rates and/or international prices for a group of clinically similar brand-name drugs (CBO, 2024). Reference-based pricing at its core is designed to also promote price transparency and cost-consciousness in prescription drug markets. Although it is an emerging strategy in the US, RBP is a common pricing method that is widely used in many other high-income international countries to determine drug prices, where laws mandate transparency in drug pricing (CBO, 2024). This regulatory transparency allows for more effective benchmarking and pricing control.

In contrast, there is a lack of price transparency within the U.S. pharmaceutical industry as a whole, which causes market dysfunctions, such as widely varied prices for similar drugs with no corresponding difference in clinical value (Whaley et al., 2019), (Feldstein, 2023). These clinically similar drugs are often referred to as "*me-too*" drugs, and although under basic economic theory, the introduction of these drugs should lead to competitive pricing, this does not often play out in reality. This is due to reasons such as patent thickets (delayed generic market entry), marketing and brand loyalty, PBM incentives (discussed earlier) and lack of price transparency (Aronson & Green, 2020; Feldstein, 2023; Jena et al., 2009). For these reasons, U.S. lawmakers are increasingly interested in applying RBP to *me-too* drugs, in hopes of fostering fairer and more rational pricing (CBO, 2024; Mulcahy et al., 2024).

The absence of a centralized, transparent source of net drug prices significantly impairs efforts to promote affordability, accountability, and informed decision-making among stakeholders (Mulcahy et al., 2024). It impedes efforts to conduct comprehensive research that aims to effectively compare US prices to international prices. Specifically, the lack of a comprehensive source of the net prices that are paid for drugs by hospitals, PBMs and retail pharmacies poses a significant limitation for research because economists must then rely on gross manufacturer prices, which they using indirect models to measure the potential rebates (Mulcahy et al., 2024). That being said, data from existing literature still reveals relevant trends in drug pricing, between the US and high-income countries, all which point to the fact that the US has much higher prices..

Figure 3: For a basket of the 10 selected drugs in 2021, the price in the U.S. is three to eight times the price in every comparison country.



Source: Gumas, E. D., Huffman, P., Papanicolas, I., & Williams II, R. D. (2024, January 4). How Prices for the First 10 Drugs Up for U.S. Medicare Price Negotiations Compare Internationally. Www.commonwealthfund.org. https://www.commonwealthfund.org/publications/2024/jan/how-prices-first-10-drugs-medicare-negotiations-compare-internationally

Literature that reveals these relevant drug pricing differences offers evidence that points to the fact that reference-based pricing can lead to substantial savings. For instance, the Congressional Budget Office conducted research on "Alternative Approaches to Reducing Prescription Drug Prices", and found that, among the approaches they studied, referenced-based pricing using international prices would lead to the most notable reduction in prescription drug prices (CBO, 2024). In the US, states have usually implemented reference-based pricing models that set maximum payments from payers (health insurers and government programs) based on Medicare rates for health services, since these data are more readily available and transparent than net manufacturer prices. Three states – Montana, California and Oregon – have implemented exemplary reference based pricing models. Specifically, an independent analysis of Montana's landmark Medicare reference-based pricing for employee health plans, found that it led to significant savings in the two years after its inception (NASHP). Translating this model to the prescription drug market, particularly in employer-sponsored insurance plans, could increase competition and reduce upward pricing pressure without imposing direct price controls.

Further, in California, the California Public Employees Retirement System (CalPERS) initiated reference pricing for knee and hip replacements in 2011. This initiative led to two major improvements: there was a high reduction in the number of patients that chose high-cost hospitals, and high-price hospitals reduced their prices to align with the reference price. Most importantly, they reported no significant change in patient outcomes (Waldrop & Brierley, 2024). In a similar vein, Oregon's "reference pricing [model] to lower its state employee health spending" set in 2017 led to significant savings. In 2017, Oregon lawmakers approved legislation that capped hospital payments made by the Oregon Educators Benefit Board (OEBB) and the Public Employees' Benefit Board (PEBB). Under the law, payments were limited to 200% of Medicare rates for in-network hospitals and 185% for out-of-network ones. These reference-based rates took effect on July 1, 2019. Before the cap was implemented, average payments from OEBB and PEBB insurers were about 215% of Medicare rates. These data highlight the effectiveness of reference-based pricing models (Waldrop & Brierley, 2024).

However, it must be noted that these reference-based pricing models were implemented in non-rural areas. In fact, the policy that was enacted in Oregon specifically excluded rural critical access hospitals, facilities with fewer than 50 beds, and those where at least 40% of revenue comes from Medicare (Waldrop & Brierley, 2024). Further, existing evidence suggests that traditional reference-based pricing models are greatly limited in rural areas due to limited healthcare competition (Sinaiko et al., 2019). This means that Vermont, being predominantly rural, would have to explore non-traditional reference-based pricing models in order to gain any efficiency from this policy route. These will be explored in the recommendations section.

Recommendations

1. Requiring PBMs to report how they reimburse 340B claims

It has already been established that inflated prescription drug cost-per-unit can be increasingly attributed to the aggressive markup practices of PBMs, and that these markup practices are made possible as a result of a lack of transparency throughout the medical supply chain. Specifically, PBMs that operate their own pharmacies are able to take advantage of discounts offered through the 340B program by misappropriating savings away from patients. For this reason, we propose that the State of Vermont requires PBMs to report how they reimburse 340B claims.

While Act 127 provides several new provisions for limiting the capacity of PBMs to capitalize on 340B discounts, such as prohibiting claims modifiers and other discriminatory contracting practices, the State can strengthen this regulation by specifically requiring PBMs to report their methods for calculating 340B claims reimbursement ("Act 127", 2024). Now that PBMs must obtain a license in order to operate in Vermont, the state has greater capacity for oversight over their reimbursement practices. Requiring PBMs to report reimbursement methodology will allow the state to identify and prevent spread pricing practices that undermine the patient cost-saving goals of the 340B program and prevent arbitrage of savings. This regulation would affect over 95% of all prescription drug transactions occurring in the state that are conducted by the one of the two PBM-controlled pharmacies, CVS Caremark and Express Scripts.

Lessons from Minnesota's 340B Covered-Entity Report

We are not aware of any other state that has implemented a policy that requires PBMs to report how they reimburse their clients. However, in 2023, Minnesota was the first state to require "340B covered entities"—a term that includes PBM-controlled contract pharmacies—to report aggregated acquisition costs and payments received for 340B drugs (H.F. 4755, 2023). The state's first 340B covered entity report, released in November 2024, found that 340B eligible Minnesota providers earned at least $630 million in 340B revenues over the 2023 calendar year (Minnesota Department of Health, 2024). This initial reporting reveals that a lack of reporting requirements for PBMs and other entities enables a redirection of savings that is at odds with the interests of the paying public.

Actionable Steps Toward Greater Transparency

The Vermont state legislature can pass a bill that requires each PBM operating in the state to submit an annual 340B reimbursement report to the Department of Financial Regulation (DFR), the entity designated by Act 127 as responsible for the oversight of PBMs. 340B reimbursement reports should include:

1. The average and median reimbursement rates paid to both covered entities and contract pharmacies for 340B drugs, and non-340B providers and pharmacies for those same drugs
2. A description of any differential reimbursement methodology applied to 340B claims versus non-340B claims.
3. Any fees or other adjustments applied to 340B claims, whether at the time that the claim is submitted or retroactively
4. Identification of any contract provisions that limit or restrict reimbursement of 340B claims.

Alternatively, now that PBMs are required to be licensed in Vermont, the Department of Financial Regulation can incorporate a requirement that PBMs submit the information (above) in the form of an annual report as a condition of obtaining and maintaining licensure in the state. However, these conditions would need to be carefully crafted such that the reporting process is not too onerous and PBMs still have sufficient incentive to operate in Vermont.

Limitations and Challenges

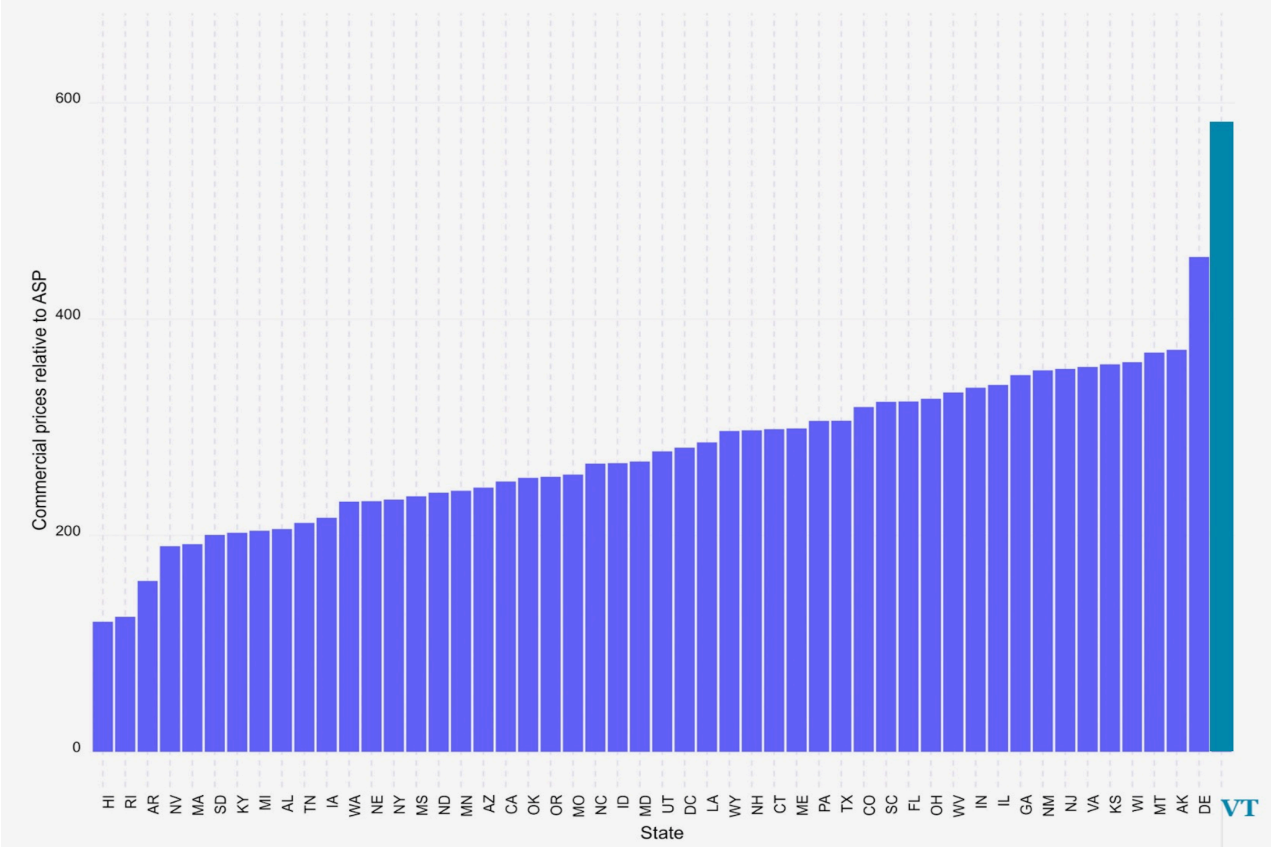
Evidently, this is a transparency-based approach to reducing prescription drug pricing, and transparency in and of itself will not solve the state's problem with oversized prescription drug expenditures. However, a lack of transparency is precisely what allows for supply chain markups to occur in the first place. Without sufficient transparency, the state cannot identify when PBM-owned pharmacies evade pricing regulations and undermine the cost-saving intent of the 340B program. Vermont has passed regulations that aim to prevent discriminatory pricing practices relating to the 340B program, but these violations cannot be identified without first imposing more stringent acquisition cost and rebate reporting requirements. Therefore, the proposed transparency policy is necessary to bolster and enforce the existing Act 127 regulations around PBM markup tactics.

We expect there to be significant pushback from PBMs themselves. The two Vermont PBMs—CVS Caremark and Express Scripts—have recently indicated to the State that "they work to lower drug prices and, in doing so, they achieve substantial savings for patients and payors" (State of Vermont v. Evernorth Inc., et al., 2024). It is possible that these PBMs will deploy their legal resources to combat any additional efforts to regulate their pricing practices. On the other hand, pharmaceutical companies themselves have articulated that they are in favor of increased transparency around 340B drug rebates, which they believe will free up resources for innovation and benefit patients in need (Janssen Pharmaceuticals, 2025).

2. Capping Physician-Administered Drug Price Markups at 120% of ASP

Capping physician-administered drug prices is recommended to decrease the high reimbursement rates that insurers and patients are paying for high-cost, specialty drugs. Though 340B revenue is intended to fund additional services and low-income individuals, steep price markups place too great a burden on insurers and payers. In reference to Figure 4, Vermont hospitals have disproportionately higher drug price markups as compared to other hospitals from states across the U.S relative to ASP. The Average Sales Price (ASP) is the average price of a drug reported by drug manufacturers after taking discounts and rebates into account (Mullen, 2007). It is a reliable estimate of drug prices and is used by the Centers for Medicare and Medicaid. In Vermont, price markups range from 231% to 1410% the ASP (BCBSVT). Steep markups for high-cost prescription drugs require insurers like Blue Cross Blue Shield of Vermont to pay high reimbursement rates (Conti and Bach, 2024). Financial pressure on insurers may force insurers to increase premiums, reducing the abilities of Vermonters to afford health insurance (Act 193). Therefore, capping the percentage that a hospital can markup a drug that is administered in the hospital can greatly reduce the burden felt by insurers and patients.

Figure 4: State-Level Hospital-Administered Commercial Drug Prices Relative to ASP in the U.S.



Whaley, Christopher, Rose Kerber, Daniel Wang, Aaron Kofner, and Brian Briscombe. 2024. "Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative." RAND. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

Why 120%?

As outlined by BCBSVT, the cap should be set at 120% of the average sales price of a drug. The additional 20% would provide coverage for administrative, handling and inventory costs (BCBSVT). The cap more closely reflects reimbursements of the Centers for Medicaid and Medicare Services (CMS) where CMS reimburses hospitals 106% of the ASP for drugs, providing the additional coverage for costs associated with inventory and handling (Robinson et al., 2024). In addition, the 340B program ensures that hospitals can purchase drugs at a discounted rate from drug manufacturers (BCBSVT). As estimated by CMS, eligible hospitals for 340B discounts purchase drugs at around 65% of the ASP. The 35% discount and 20% markup ability, will still permit hospitals to generate revenue to support services and administration costs (BCBSVT).

Impacts on 340B Revenue

The purpose of the 340B Drug Pricing Program is to support low-income and underinsured individuals. However, the exact use of 340B revenue is unknown. The lack of requirements for reporting 340B revenue, creates uncertainty in how it is being spent and who it is being spent on (Knox et al., 2023). Though, the financial implications that this cap on hospital-administered drug markups would have on hospital funding sources have been considered. An estimate by BCBSVT, finds that 90% of total cost savings for BCBSVT based on the top 50 outpatient drugs for FY 2025 or 2026, will be generated by the University of Vermont Medical Center, Rutland Regional Medical Center and the Central Vermont Medical Center (BCBSVT). Moreover, all three hospitals ended FY 2024 with positive operating margins, suggesting that this proposal is financially feasible (Green Mountain Care Board, 2025).

How would this be implemented?

Bill H.266, "an act relating to the 340B prescription drug pricing program," needs to be amended by the Vermont State Senate Committee on Health and Welfare to include legislation that caps hospital-administered price markups at 120% the Average Sales Price for 340B participating hospitals. An amendment should be proposed by the Senate to include an additional section that proposes the 120% cap of ASP for hospital-administered drugs in 340B. It should be made effective immediately upon passing.

Limitations and Challenges

Most of the opposition to this policy change would be voiced by hospitals. The American Hospital Association argues that the revenue that is generated by 340B supports rural hospitals and maintains access to specialty services (AHA). Hospital pushback would need to be considered before implementing this policy.

3. Creating reference-based pricing models tailored for the rural setting in Vermont

When it comes to efforts to reduce prescription drug prices, the state of Vermont has emerged as one of the states that are policy innovators. On May 16, 2018, the Vermont senate signed Act 133, which laid the groundwork for importing prescription drugs from Canada to reduce costs (Act 133, 2018). It became the first state in the U.S. to enact legislation authorizing the importation of lower-cost prescription drugs from Canada (NASHP). Although the state's effort to operationalize this drug importation program remains on hold, due to delayed federal approval, the passage of Act 133 highlights Vermont's persistent commitment to exploring innovative strategies that expand access to affordable medications for its residents. Thus it comes at no surprise that Vermont is also actively looking into and investigating reference pricing models as part of broader cost-containment efforts. Act 113 (Sec. E.345.2) of 2024 tasked the Green Mountain Care Board to contract a qualified organization to conduct a reference-based pricing (RBP) analysis. Health Management Associates (HMA) was contracted to perform the data analysis. HMA conducted a study that examined commercial medical claims for inpatient and outpatient hospital services and supplies incurred by members and dependents of the State Employees' Health Benefit Plan and the Vermont Education Health Initiative, using data from 2018 through the most recent available year. The analysis estimated potential savings if a Medicare-based RBP model had been applied during that period (GMCB, 2024).

The HMA study included most inpatient and outpatient services, including drug administration, and found that if prices for these hospital-based services had been paid at 200% of the Medicare base rate during this

study period, estimated potential savings would have been about $400m (GMCB, 2024). These are significant savings. The Green Mountain Care Board (GMCB) further laid out four recommendations for legislative action if reference-based pricing is implemented. Namely, these are ensuring fair and financially sustainable implementation that considers provider and taxpayer impact; strengthening patient protections against balance billing; conducting further analysis on service-specific adjustments and potential market effects; and aligning any RBP efforts with Vermont's broader health care payment reform initiatives (GMCB, 2024). We adapt and build on these recommendations to propose how reference-based pricing can be specifically applied to prescription drug policy in Vermont:

1. Implementation should ensure fairness and financial sustainability

A reference-based pricing (RBP) model for prescription drugs should ensure fair and sustainable reimbursement levels for healthcare providers (including hospitals and pharmacies), especially in more rural settings where access is already fragile. One way that this could be done is to implement a tiered reference pricing model, where Medicare rates are the standard, whereas higher reimbursement rates could be offered to rural pharmacies or to pharmacies dispensing high-value, low-cost generic medications, to preserve access and reward efficiency. Furthermore, rather than targeting manufacturers directly (which would prove difficult), the policies surrounding the RBP model could look to reforming how PBMs (as discussed in an earlier section) set prices, reimburse healthcare providers, and manage formularies. Lastly, drugs that have more therapeutic equivalents should be first on the list for an RBP model.

2. Patient Protections Against Cost-Shifting Are Essential

In Act 113, the GMCB recommended that legislators should consider strengthening existing laws or offer new safeguards to prevent cost burdens from shifting to patients under a RBP model. On a similar note, Vermont should strengthen protections against excessive cost-sharing in drug pricing, ensuring that RBP implementation does not lead to unexpected out-of-pocket expenses for patients. This could include capping limits on patient copays and/or requiring that insurers fully cover at least one drug per therapeutic class within the pricing model.

3. Ongoing Impact Analysis and Flexibility Are Critical

For this recommendation, in Act 113, the GMCB stated that further study is necessary to evaluate potential adjustments for specific types of care, such as mental health services, primary care, as well as obstetrics and gynecology services, where higher reimbursement levels may be warranted. Further, impact on other plans used by Vermonters, such as the Qualified Health Plan Exchange market, should be well-assessed. We propose that similar measures be taken when implementing a RBP model for prescription drugs. Practically, this could include establishing special monitoring protocols for the high-need areas highlighted above, and/or establish a review committee to annually evaluate and adjust prescription drugs for these pertinent healthcare services. It is also important to examine how reference pricing would affect reimbursement to pharmacies, especially those that could be harmed if rates fell below sustainable levels. However, this would require transparency from insurers, PBMS and the pharmacy themselves. Furthermore, access to more detailed drug pricing data, segmented by pharmacy and therapeutic class, would enable more precise policy design, help avoid unintended consequences, and support the development of tailored RBP models.

Conclusion

PBMs, hospitals, as well as payers, are receiving an increasing proportion of total expenditures on brand-name prescription drugs. Notably, in 2023, 25% of all brand-name drug spending went directly to PBMs, insurers and other supply chain entities. 340B provider markups also accounted for 10% of all brand-name drug expenditures (Blalock et. al, 2025). There are several ways in which the state of Vermont can act to reduce aggressive supply chain markups by imposing stricter regulations on PBMs and hospitals. Namely, the state can require PBMs to report their reimbursement practices for 340B claims, cap hospital price markups on hospital-administered drugs, and implement a reference-based pricing model for prescription drugs that is tailored for the Vermont rural healthcare system.

We have found that:

- Vermont has passed regulations that aim to prevent discriminatory pricing practices around the 340B program, but the state does not require sufficiently robust acquisition cost and rebate reporting from PBMs. Without sufficient transparency, the state cannot identify when PBM-owned pharmacies evade pricing regulations and undermine the cost-saving intent of the 340B program. Therefore, Vermont must pass legislation that requires PBMs to report their 340B claims reimbursement practices to the Department of Financial Regulation.
- Vermont 340B participating hospitals have been found to charge upwards of 1410% ASO for a single drug. Excessive price markups for hospital-administered drugs in Vermont 340B participating hospitals force private insurers to increase their premiums to cover these highly expensive drugs. Therefore, the Vermont State Senate must amend the current bill, H.266 to include legislation that caps price markups of physician-administered drugs to 120% of their ASP.
- Reference-based pricing (RBP) has the potential to reduce prescription drug costs in Vermont, by aligning reimbursement levels with Medicare benchmarks. However, for a RBP model to be successful in a predominantly rural state like Vermont, it must be carefully tailored to address the unique challenges of rural healthcare access, small pharmacies, and vulnerable populations. Therefore, Vermont must implement a RBP pricing model that will maintain fair reimbursement levels, as well as protect patients from excessive cost-sharing.

Throughout this process, we have gained a deeper understanding of the fragmented nature of Vermont's prescription drug payment system. We were surprised to learn that relatively little is known about where cost savings from the 340B Drug Pricing program actually end up. While the aim of the program is to provide discounted drugs to eligible entities, there is limited oversight in regards to what stakeholders actually receive these discounts, and it is likely the case that PBMs and hospitals are taking in revenues from discounted drugs that were meant to be passed down as savings to patients. Further, we were surprised to come across a myriad of contradictory sources when researching possible policy recommendations. This underscored not only the complexity of health policy but also the deep sensitivity and fragmentation of the prescription drug pricing landscape in the United States.

As we had the opportunity to meet with many different experts throughout this process, we came to recognize the diversity and number of stakeholders that are invested in reducing prescription drug costs in Vermont and improving health outcomes for the Vermont population. The policies that we proposed will require collaboration among these stakeholders.

Appendices

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