***Why did you set the cap at 120%?***
120% is equivalent to the price that insurers are able to procure these drugs from their PBMs. Therefore, this is equivalent to the white bagging price that passed in the Senate version of H.266.
120% is the average markup price for these drugs from all sources, not just hospitals.

Vermonters needs real price relief. This would allow the GMCB to reduce the requested rates for Blue Cross VT health plans offered through Vermont Health Connect by 4% on average. That's a meaningful price reduction.

This is the only proposal that will lead to a tangible decrease in costs for Vermonters immediately.

Private practices in Vermont are paid 110% of ASP for drugs administered in their locations. A good example is Champlain Valley Hematology and Oncology. Patients receiving transfusions at this practice pay a fraction of the price that patients in our hospitals do for the exact same drugs.

These massive differentials in reimbursement rates have led to the calls in Vermont for site-neutral pricing. This bill evens the playing field for independent Vermont practices and reduces the inequities among patients.

***This benefits out of state insurance plans, not just Blue Cross VT, why would we do that?***
This isn't about health insurance companies. This is about the excessive cost of Vermont's health care system for everyone.
The proposed Legislation would benefit all Vermonters, no matter where they get their health care coverage. Our system is just plain unaffordable. This is one of the reasons why Vermont has the highest health care costs and the highest insurance premiums in the country.
These are people receiving infusion treatments in our hospitals for cancer, not tourists.
This isn't about benefiting Blue Cross VT as a company this is about patients/members/Vermonters. If it was only done for Blue Cross VT members there would be perverse results – your family/friend/neighbor's drugs cost $85K while yours cost $1,300 for the same drug?

There are ~54,000 Vermont residents covered by non-Vermont Blues. Why shouldn't they benefit? They live and work in Vermont but have coverage through a national employer that is headquartered outside of our state.

Cigna, for example, is the health plan for a number of important Vermont employers: National Life, St. Michaels College, should all of these employers and employees be excluded from benefitting?

Finally, our state is not competitive because of our high health care costs. National employers are not locating workplaces in our state and remote workers are choosing not to live here because of the high cost of health care. A parochial solution is not the answer to this problem.

***Why did you exclude Critical Access Hospitals, but not PPO hospitals or the hospital in my community?***

We believe in fair pricing, but we also recognize the pressures that our small critical access hospitals are under. This was our compromise to address the eggregous pricing issues and allow smaller hospitals with slimmer margins more time to work on delivery system reform.
We also reviewed the Operating Margins and Days Cash on Hand that were just reported to the GMCB this week. This targets the price caps toward the hospital where there is sufficient margin.

***What happens next?***

This 120% cap is part of our larger health care system reforms.
We have all of the provisions in S.126 and the current work being done by AHS with the Rural Health Redesign Center and our hospitals.
We are financing the support these hospitals need to reorganize, become sustainable, and find savings for Vermonters.

**Neulasta example** (assuming 72 HCPC units per year)
ASP $18.85 x 72 = $1,357 per year
Independent oncology practice is 110% ASP 110% ASP = $20.74 x 72 = $1,493.28 per year (Champlain Valley Hematology and Oncology)
UVMMC charge markup $1,310.77 x 72 = $94,375 per year (6,954%)
BCBSVT Reimbursement $1,187.63 x 72 = $85,509 per year
H.266 Proposal 120% ASP = $22.62 x 72 = $1,628.64 per year