Dr. Stephen Leffler Testimony on H. 266
Senate Health and Welfare Committee
May 29, 2025

- You have heard about the data and high charges, we can speak to that but the fact of the matter is yes all hospitals charge more than the drug is purchased and get paid by commercial payers more than the drug costs us.
- There is constant discussion about hospitals with 340B status having the largest "mark up"—the purpose of the 340B program is to help sustain services to populations that cannot cover the cost of the service and to subsidize the care to communities where there is a proven need.
- Within health systems we cross subsidize services, you have heard that before. The financial model all our hospitals are built on is a total revenue model where to be financially stable hospitals need to cover costs and make some additional revenue to maintain facilities and support care to the community.
- When hospitals and payers establish rates, they are looking at total revenue. BCBSVT has said that our pricing increases are in line with GMCB approved budgets and rates. The rates are built on a system that has been in place for too long resulting in our current situation
- We need payers at the table working with us to establish reimbursement for lower cost biosimilars, work on referenced based pricing and understanding how they set formularies and work with their pharmacy benefit managers—we do not control the whole process here and we need to collaborate. We did this with one payer last year resulting in significant reductions in reimbursement for infusion services.
- If you pick at the services that cover cost of that service and other services you are limiting the overall revenue in a system and frankly to do this with a blunt instrument you will cut services and where will those patients go?
- We are already working to find space for a local provider, doing these exact services. If we did not bring him on as an employed provider, he would simply close the office significantly reducing services to our community. To do this we are looking at opening services in Middlebury, finding space for chairs, and finding staff to support the additional patients. If Northwestern shuts down infusion services, we cannot absorb that volume—-so where does a patient needing cancer infusions go? Dartmouth, Boston? Can they even get into those hospitals? What about the family with no child care or transportation?

- We know that drug costs are a problem, and we are already working on our assessment of moving to referenced based pricing in a thoughtful manner that would address this issue. We would look to understand from our payers how they work with PBMs and set formularies to make sure we are all doing everything we can to get the lowest cost drug to our patients and support the financial stability of the providers that serve them.