Green Mountain Care Board

Act 134 of 2024

Final Report

Prescription Drug Affordability in Vermont

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Contact Information

From:
Kathryn O'Neill, Director of Prescription Drug Pricing
Green Mountain Care Board
kathryn.oneill@vermont.gov, 802-272-8602

Michelle Luengas Lozano, Health Policy Analyst for Prescription Drug Pricing
Green Mountain Care Board
michelle.lozano@vermont.gov, 802-661-8077

To receive this information in an alternative format or for other accessibility requests, please contact:
Kristen LaJeunesse, Communication & Information Officer
Green Mountain Care Board
Kristen.LaJeunesse@vermont.gov 802-622-4134

About this Report

Act 134 of 2024 (S.98) directs the Green Mountain Care Board (GMCB), in consultation with others, to create a framework and methodology for implementing a program to regulate prescription drug costs in Vermont. This is the final report submitted to the Legislature as required by this statute. This report includes descriptions of potential opportunities and recommendations for the State to consider in its effort to reduce the cost burden of prescription drugs. The GMCB remains deeply committed to serving as an unbiased source of information, and to monitor and evaluate options that the Legislature determines to be the best path forward.

This report is made possible through contract support from Onpoint Health Data and Horvath Health Policy.

About Jane Horvath

Jane Horvath is an experienced health policy analyst and policymaker with a deep background in prescription drug pricing, reimbursement, and the impacts of regulation on the commercial, Medicaid, and Medicare insurance markets. Ms. Horvath spent ten years at Merck, worked for Medicaid directors, the U.S. Senate Finance Committee, and served as Deputy Assistant Secretary for Legislation at the U.S. Department of Health and Human Services. She established the Center for State Prescription Drug Pricing at the National Academy for State Health Policy (NASHP) and has been a researcher at Johns Hopkins University as well as the federal Medicaid and CHIP Payment and Access Commission (MACPAC).

About Onpoint Health Data

Onpoint Health Data is an independent, nonprofit health data organization based in Portland, Maine, with more than 40 years' experience developing and delivering independent, innovative, and insightful health data solutions to clients nationwide. Over the past two decades, Onpoint has developed and maintained more than half of the country's All Payer Claims Database (APCD)s, expanding their value through the integration of non-claims data sources such as alternative payment model, social determinants, and clinical data. At Onpoint, staff consist of a highly collaborative team of health data professionals, including software engineers and architects, project management professionals, health data analysts, security and compliance experts, and more. Onpoint leverages advanced data analytics, machine learning, and secure cloud-based technologies to provide comprehensive solutions that help policymakers, researchers, and the public understand how healthcare is being delivered – and how it can be improved – based on reliable, trusted data.

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Executive Summary

The high cost of prescription drugs in Vermont continues to be a major concern for Vermonters, despite numerous significant efforts by the State over the years. In 2024, Act 134 authorized the Green Mountain Care Board to explore novel strategies to make prescription drugs more affordable. This effort faces significant challenges due to Vermont's unique demographics, including the state's small population, which limits its leverage in a global pharmaceutical market. The effort also faces challenges that are legal in nature, such as those imposed by the Commerce Clause of the U.S. Constitution, which grants the U.S. Congress the sole ability to regulate interstate commerce and limits states' authority to mandate lower prices through state legislation. While these challenges are considerable, recent and ongoing innovations in the pharmaceutical market – and specifically in the market for generic drugs and biosimilar products – offer Vermont a real opportunity to significantly reduce prices on a wide range of prescription drugs.

Vermont should focus on voluntary, market-based efforts in which the state acts as a market participant rather than a regulator. In the generic space, the State should leverage market disruptors that focus on affordability as suppliers for the Vermont market and reduce prices for all residents. In the brand space, innovations like direct-to-consumer sales are emerging, although at this time it is not yet clear how beneficial these changes in overall brand costs might be to Vermont. Further monitoring and evaluation will be required as these changes can, and often do, occur rapidly, reshaping the market and opening additional opportunities. Market disruptors like Civica Rx (for hospital inpatient drug supply) and Cost Plus Drug Company (for outpatient retail prescription drugs) have adopted a new business model that goes beyond merely lowering the price of expensive generic drugs but rather, aims to make those drugs truly affordable for consumers through a transparent pricing structure based on cost. These disruptors, which will be discussed in more detail in this report, have developed the infrastructure necessary (e.g., manufacturing, wholesale services, and administrative capacity) to make their products widely available and could be tapped as suppliers for Vermont pharmacies, facilities, and residents. To encourage the adoption of these suppliers, Vermont health plans and PBMs should tie their reimbursement rates for different prescription drugs to the publicly available prices from these new market disruptors. This approach must consider the myriad stakeholders participating in the Vermont pharmaceutical market and ensure that these stakeholders are not harmed by a shift to these new suppliers.

Other approaches to the generic market are also worth considering. For example, the State could coordinate a coalition of Vermont health plans and encourage them to contract with smaller, independent PBMs that are more open to payment innovation and help develop a model contract for these health plans that focuses on transparency and clear terms.

In addition, the State should consider the distribution of pharmacy discount cards to Vermonters through non-profit organizations like ArrayRx. It is also possible to consider the creation of a nonprofit, State-sponsored drug wholesaler, but ongoing changes in the market and administrative requirements may make feasibility challenging in the long term.

In terms of brand name drugs, major changes are underway in the industry, with manufacturers increasingly adopting a direct-to-consumer approach for select expensive drugs and some insurers looking to eliminate opaque rebates that drive up costs. These changes are in their early stages and their impact – and potential value to Vermont residents – cannot yet be known. In 2026, the first phase of the Medicare price negotiation program will be implemented, with 10 selected drugs now subject to the Medicare Maximum Fair Price (MFP). Recent changes to the program, however, suggest it may not bring the savings that were initially expected. Some states have expressed interest in extending the MFP to all populations, not just Medicare beneficiaries. Vermont analyzed the impact of such an extension, which is discussed later in this report, and should continue to monitor these efforts.

To move forward, Vermont should create a statewide advisory committee composed of members with significant expertise in the Vermont pharmaceutical market to develop a plan for how to implement these approaches in a way that is beneficial to all stakeholders.

Vermont should also invest in expanded prescription drug price transparency efforts, similar to other states' programs that have developed in recent years. While price transparency and data collection alone are not sufficient policy solutions, Vermont needs more reliable and timely data collection for analysis, monitoring, and evaluation to better inform policy solutions and program development.

Introduction

Vermont has consistently implemented policies to try to constrain prescription drug spending, including passing a robust set of statutes governing pharmacy benefit manager (PBM) market behavior, creating greater transparency in the financial benefit hospitals receive from participating in the federal 340B program, and limiting charges for hospital-administered pharmaceuticals. Despite these efforts prescription drug spending continues to be a growing source of financial strain for the state. Act 134 of 2024 authorized the Green Mountain Care Board (GMCB) to explore new cost-containment opportunities to ensure that Vermonters have greater access to lower-cost retail prescription drugs.

This report follows and builds upon two earlier reports produced in 2025, entitled, respectively, "Act 134: Preliminary Report on Implementing a Vermont Prescription Drug Cost Regulation Program[1]" and "Addressing the Costs of Prescription Drugs in Vermont: Review of Existing Efforts and Possible Paths Forward.[2]" These reports reviewed how smaller states are working to constrain prescription drug costs for consumers, health plans, and providers.[3] This third and final report provides additional recommendations for Vermont policymakers.

As discussed in previous reports, Vermont's small population limits its ability to exert market leverage on international conglomerates in a global pharmaceutical market, and the Commerce Clause of the U.S. Constitution limits the state government's ability to implement cost control directly through legislation. In addition, the complex nature of the pharmaceutical market and its myriad stakeholders – manufacturers, wholesalers, health plans, PBMs, and providers – and competing incentives make coordination difficult but essential to maximize the state's limited leverage. The challenges are discussed in detail in Appendix A.

Recent and ongoing innovations within the U.S. pharmaceutical market offer the best way forward for cost containment in Vermont. These innovations include:

- Drug manufacturers selling directly to cash-only-paying consumers or to pharmacies that agree to limit what is charged to consumers at the point of sale
- Wholesalers creating new lines of business in addition to traditional wholesale distribution
- Nonprofit and low-profit generic drug makers – like Cost Plus Drug Company – marketing very low-cost generic or biosimilar versions of branded drugs and using

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1 Preliminary report on implementing a Vermont prescription drug cost regulation program. Green Mountain Care Board. January 15, 2025. Link (accessed January 7, 2026): https://gmcboard.vermont.gov/sites/gmcb/files/documents/Act134_Prelim_Rpt_FINAL_1-15-2025.pdf

2 Addressing the costs of prescription drugs in Vermont: review of existing efforts and possible paths forward. Green Mountain Care Board. May 19, 2025. Link (accessed January 7, 2026): https://gmcboard.vermont.gov/document/addressing-cost-prescription-drugs-vermont-review-existing-efforts-and-possible-paths

3 Many of the state initiatives from those reports are updated and included in Appendix B.

dedicated or in-house distributors to ensure the low cost is passed through to the provider and consumer

- Entry of the fully transparent Medicare Maximum Fair Price into the U.S. market

These advances present an opportunity for Vermont (most notably in the generic market) but also introduce an additional element of uncertainty. Market disruptors and new regulatory frameworks will undoubtedly reshape the overall market and lead to further changes as suppliers adjust to a new "normal" and modify their own business models to gain advantage. Those changes may create additional pathways for Vermont to reduce the costs of prescription drugs, particularly in the branded market; however, too much remains unknown to say with confidence exactly what those pathways may be. These areas will require continued monitoring to determine their potential value to Vermont.

In the following sections, we will discuss the most promising avenues for cost containment. First, for the generic market, we will discuss how Vermont could leverage two market disruptors – Civica Rx and Cost Plus Drug Company – to lower costs for all residents for a wide range of common retail prescription drugs and how that could be operationalized across the state without harming key stakeholders.

Next, we will discuss additional approaches to the generic market that are more policy-oriented and may require legislation, including encouraging Vermont health plans to contract with an alternative, more flexible PBM open to payment innovation, the creation of a nonprofit, State-sponsored wholesaler, and the distribution of prescription discount cards from existing organizations like ArrayRx.

Finally, we will turn to the branded market, where the impact of the newly implemented Medicare Maximum Fair Price program is not yet known, but where manufacturers are innovating through direct-to-consumer sales and the potential end of PBM rebates.

Drug Cost Containment for Vermont

Vermont's small population means that the State's best approach is to focus on voluntary, market-based efforts involving state entities acting as market participants (rather than as regulators) and encouraging the voluntary participation of the private sector.

To encourage the participation of a critical mass of private and public sector stakeholders, any successful cost-containment policy must first secure and maintain the robust support of in-state stakeholders. To bring costs down for everyone, this strategy must consider the role of each of these stakeholders – including direct purchasers (inpatient facilities, outpatient clinics, pharmacies, specialist medical practices), employers, commercial and government health plans, and consumers – as well as the potential benefit each stakeholder group could derive from the strategy's implementation.

The most feasible options for reform in Vermont are in the market for generic and biosimilar products. Market entrants with business models focused on providing truly low-cost drugs – rather than drugs with a significantly reduced price compared to a branded drug – could reduce costs for residents without harming providers or retail pharmacies. The following section explains how these programs could work and how they could be operationalized across the state.

Lowering Generic Drug Costs

Vermont could consider supply-side policy approaches that would bring lower cost generic and biosimilar drugs into the state for direct purchase by facilities, pharmacies, and medical practices that dispense or administer drugs. The most viable supply-side approach involves generic drugs and biosimilar products only.

Statewide Purchase of Innovative Generic Manufacturer Products

There is significant private sector innovation in the generic market because there are no constraints, such as patents, on who can manufacture and sell generic products (subject to FDA approval and licensure). The generic market is, generally speaking, very competitive on price, which is what can make this market unstable, leading to periodic shortages of generic products. In this market, price concessions are often provided at the time of the sale ("on-invoice") in contrast to brand price concessions, which are traditionally provided through post-sale rebates.

Generic market disruptors provide significant savings for people and entities willing to think "outside the box." Because many generic drugs are widely used by patients (high-volume products), even small per-unit savings can add up to significant savings overall. Similarly, lower-volume, high-cost generic drugs provide significant savings relative to the original branded innovator product. Currently, there are two generic market disruptors that could play a role in Vermont efforts to reduce drug costs for purchasers, health plans, and consumers: Civica Rx and Cost Plus Drug Company. In the future, there may be more.

Generic Drug Supply – Hospital Inpatient Services

Civica Rx is a nonprofit, generic prescription drug company established in 2018. Its original sponsors were primarily a consortium of hospital systems looking to produce generic products crucial to inpatient hospital care and that were often in acute, life-threatening shortage. Participating member hospitals make advance purchase commitments of Civica Rx drug products.[4] Civica Rx has contracted with the wholesaler Cencora (previously Amerisource Bergen) to distribute its drug products to member facilities nationwide.[5] Civica expanded to include insurers, primarily Blue Cross Blue Shield companies, including Blue Cross Blue Shield of Vermont, and state-sponsored health plans in California, to develop and distribute retail generic products in addition to hospital-administered generics. As part of this effort, Civica Rx built and is manufacturing low-cost insulin products in the United States.

Civica Rx has approximately 55 health system members, including roughly 1,500 hospitals, that can access its 80 generic medications. No Vermont hospitals have chosen to participate in Civica Rx, but several hospitals do participate in group purchasing organizations (GPOs) that help contain costs. GPO savings come from high-volume purchase contracts on behalf of hospital members. It is likely that transferring some of this hospital purchasing to Civica Rx would reduce the overall volume of drugs that would be purchased through the GPO, but this shift in supplier is unlikely to significantly affect contracts as they are executed through separate and distinct distribution channels. The topic of supplier contracts is discussed later in this report.

Support from the State has the potential to boost the participation of Vermont facilities in these lower-cost suppliers. For example, the State could pay Civica Rx membership fees or address through legislation some wholesaler contract provisions that limit the ability of an individual facility to contract with different suppliers for different products.

Because inpatient hospital services are often billed as a bundled service, it is unclear whether the savings realized from a Civica Rx membership would translate into direct, dollar-for-dollar benefits for insurers and consumers, but it could lower hospital drug purchasing expenses. Savings created through a unified supply system that strengthens Vermont hospitals' financial stability would provide a meaningful indirect benefit.

Generic Drug Supply – Outpatient Retail

Cost Plus Drug Company (Cost Plus) started in 2022 as an online pharmacy of generic drugs meant for cash-paying customers. To keep costs low, Cost Plus started as a mail-order-only pharmacy business that did not accept insurance but has since expanded operations rapidly and now contracts with insurers. For its mail-order drugs, Cost Plus uses a transparent pricing formula that consists of the manufacturer's cost plus a 15% markup, a $5 dispensing fee, a $6.25 maximum shipping fee (which varies depending on the number of prescriptions in an order), and a credit card processing fee of up to 3

[4] Advance purchase commitments smooth market operation: supply meets demand eliminating the chance of a shortage, and price is maintained, assuring revenue that covers company costs.

[5] Amerisource Bergen kicks off strategic relationship with Civica. Civica. January 24, 2023. Link (accessed December 2025): https://civicarx.org/amerisourcebergen-kicks-off-strategic-relationship-with-civica/ accessed December 2025

percent. Recently, Cost Plus announced the availability of a biosimilar of the innovator drug Stelara, which will be available at a 90% discount.[6] [7]

In 2022, before Cost Plus had its own manufacturing and wholesaler capabilities, the company signed an agreement with a coalition of 40 large private and public employers to make its products available to their enrollees.[8] To make that project work, the employer and insurer coalition created a PBM, EmsanaRx (now called AffirmedRx), to manage the billing and remittance relationship between Cost Plus, enrollees, and the health plans. Since the 2022 arrangement between the coalition and Cost Plus, the company has onboarded its own PBM, which, as of February 2023, is SmithRx.

Cost Plus has become a one-stop shop to address the variety of arrangements necessary to make its products widely available. In addition to its own PBM, Cost Plus includes a wholesale component, a specialty pharmacy component (Expion, for drugs requiring special handling), and its own in-house manufacturing. It sells directly to approximately 4,000 pharmacies that agree to pass savings onto consumers who have a Cost Plus discount card, as well as directly to consumers through mail order.[9]

The Penn Medicine health system recently contracted with Cost Plus for the routine provision of 100 generic drugs to its pharmacies, clinics, and inpatient facilities.[10] This could be the model for enhancing statewide supply of generic drugs in a Vermont system.

The market for insulin, a drug of significance for Vermont, where nearly 8% of the population has diagnosed diabetes,[11] is changing rapidly. Civica Rx has announced a plan to manufacture and distribute multiple biosimilar insulins, including a biosimilar version of Lantus insulin glargine (a long-acting insulin) for the retail outpatient market. The Civica Rx version will be available in January 2026 for $45 for a 5-pen package. This price will be available only to U.S. pharmacies that agree to limit markup to $10. Three

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6 The innovator biologic, Stelara, was subject to Medicare price negotiation and that price will be in the market January 1, 2026. Drugs that have generic or biosimilar competition are not subject to price negotiation and, for drugs that did not have competition in the year of negotiation, the Medicare price limit is lifted.

7 Cost Plus Drugs and Oread Rx to launch OTULFI™, an affordable STELARA® biosimilar in April 2025. Oread Rx. April 21, 2025. Link (accessed December 2025): https://www.prlog.org/13072721-cost-plus-drugs-and-oread-rx-to-launch-otulfi-an-affordable-stelara-biosimilar-in-april-2025.html

8 Bushard, B. Mark Cuban's Cost Plus Drugs expands to employers in quest to disrupt big pharma. Forbes. December 10, 2022. Link (accessed December 2025): https://www.forbes.com/sites/brianbushard/2022/12/10/mark-cubans-cost-plus-drugs-expands-to-employers-in-quest-to-disrupt-big-pharma/

9 Meara, K., et.al. Mark Cuban Cost Plus Drugs affiliate pharmacy network aims to support independent pharmacies. Drug Topics. June 3, 2025. Link (accessed December 2025): https://www.drugtopics.com/view/mark-cuban-cost-plus-drugs-affiliate-pharmacy-network-aims-to-support-independent-pharmacies

10 Li, E. Penn Medicine partners with Mark Cuban's Cost Plus Drugs to increase medication supply, reduce costs. The Daily Pennsylvanian. January 20, 2025. Linke (accessed December 2025): https://www.thedp.com/article/2025/01/penn-medicine-partners-mark-cuban-prescription-drug-efficiency

11 Diabetes in Vermont: data and facts. Vermont Department of Health. Undated. Link (accessed December 2025): https://www.healthvermont.gov/wellness/diabetes/diabetes-vermont-data-facts

additional biosimilar insulins are expected soon.[12] Presumably, the default distribution will be through the Civica Rx wholesaler, Cencora. This could also be included in a Vermont generic/biosimilar cost reduction plan.

Recently, due to political pressure and the threat of Civica's generic introductions, there have been steep price reductions in the insulin market. As a result, Cost Plus announced in late 2023 that it will not manufacture or sell biosimilar insulins as it had originally planned to do.[13]

Analysis of Potential Savings from a Cost Plus Model

We analyzed the potential savings in Vermont for leveraging a Cost Plus model for purchasing prescription drugs at a discount. Cost Plus drugs are priced at manufacturing cost + 15%.

Our analysis showed that drugs on the Cost Plus formulary currently comprise approximately 27.4% of total retail pharmacy spending in the state This approach could yield potential savings of up to $23.6 million, with a projected 64.9% reduction in prices for drugs on the formulary (**Figure 1**).

Figure 1. Estimated Potential Savings from Switching to a Cost Plus Model (2025)

	Total Prescriptions Filled from Cost Plus Formulary	Total Spending on Cost Plus Drugs Formulary (estimated 2025)	Projected Spending if Switched to a Cost Plus Model	Total Projected Annual Savings Under Cost Plus Model	Projected % Savings Under Cost Plus Model
Commercial	178K	$9.3M	$3.8M	$5.4M	58.7%
Medicaid	179K	$6.9M	$2.8M	$4.1M	59.4%
Medicare	393K	$20.3M	$6.2M	$14.1M	69.6%
All Payers	749K	$36.4M	$12.8M	$23.6M	64.9%

Note: These figures include projected savings for self-insured commercial plans not included in the VHCURES database. They also include estimated adjustments for inflation in spending between 2023 and 2025.

[12] Civica to launch long-acting insulin glargine in the us in January 2026. Civica. October 15, 2025. Link (accessed December 2025): https://civicarx.org/civica-to-launch-long-acting-insulin-glargine-in-the-us-in-january-2026/ Note also that California has a contract with Civica Rx for distribution of the new generic insulin as noted in the press release; the operational details are beyond the scope of this paper.

[13] Twenter, P. Cost Plus Drugs ends plan to sell insulin. Becker's Hospital Review. June 14, 2023. Link (accessed December 2025): https://www.beckershospitalreview.com/pharmacy/cost-plus-drugs-ends-plan-to-sell-insulin/#main.

Table 1. Price Savings for Example Drugs from the Cost Plus Formulary

	Abiraterone Acetate (Prostate Cancer) NDC: 68462088260	Bupropion XL (Depression) NDC: 68180032002	Lisinopril (Hypertension) NDC: 68180098003
Average Price per Unit Paid in Vermont (VHCURES)	$111.79	$0.49	$0.14
Price if Purchased through Cost Plus	$1.53	$0.08	$0.02
Savings per Unit	$110.25	$0.41	$0.12
Cost Plus Drugs % Savings per Unit	98.6%	83.5%	86.3%

Prices per unit paid in Vermont (derived from VHCURES data) in 2023 were adjusted for inflation using the medical Consumer Price Index (CPI) price growth for medical commodities in New England between 2023 and 2025 (4.0% in 2024 and 3.6% in 2025). Prices adjusted for inflation were compared to 2025 pricing for the Cost Plus formulary. **Table 2** shows the potential aggregate savings for the example drugs if all prescriptions in Vermont were bought through Cost Plus.

Table 2. Example Savings in Aggregate for Drugs on the Cost Plus Formulary

	Abiraterone Acetate (Prostate Cancer) NDC: 68462088260	Bupropion XL (Depression) NDC: 68180032002	Lisinopril (Hypertension) NDC: 68180098003
Total Spending on Cost Plus Drugs Formulary (estimated for 2025)	$214,518	$194,991	$202,051
Cost Plus Drugs % Savings per Unit	98.6%	83.5%	86.3%
Total Potential Savings through Cost Plus Drugs	$211,575	$162,808	$174,394

Explore the full Cost Plus Drug Company Repricing Analysis here[14].

[14] GMCB prescription drug affordability program: Cost Plus Drug repricing analysis. Green Mountain Care Board. Undated. Link: https://public.tableau.com/app/profile/onpointhealthdata/viz/VTGMCBPharmacyAnalysis/CPD

Generic Wholesale Supply – Operational Aspects for Inpatient & Outpatient

Leveraging Both Civica Rx & Cost Plus

The overall design of a statewide generic drug supply program would leverage Civica Rx (for inpatient-related products) and Cost Plus (for self-administered drugs) as suppliers for Vermont providers, who would order from the two companies directly. The system would be facilitated by health plan drug reimbursement based on the publicly available acquisition costs of the drugs supplied from either Civica Rx or Cost Plus. Pharmacies and other dispensers could purchase the products from other sources but would have incentive to do so only if the products cost less than those of Cost Plus or Civica Rx. For the consumer, the process would be seamless; for medical professionals and other entities, the process should be consistent with standard drug acquisition and billing processes.

Inpatient providers like hospitals could order products directly from Civica Rx for inpatient use, as from any other supplier.

Outpatient providers (e.g., medical practices and pharmacies) could purchase insulin directly from Civica Rx. Those who wanted to use another wholesale source would be limited – by insurer or PBM reimbursement rates – to billing no more than the Civica Rx price for the equivalent product.[15] As mentioned in a previous section, the State may need to examine if and how certain wholesalers link a discount on one product to the purchase of another. Should such contract provisions make it difficult for retailers to use the lower-cost Cost Plus or Civica Rx products relative to a commercial wholesaler, there may be a need for statutes that limit such contract provisions.

If it is sensible to limit Cost Plus purchasing to a specific set of drugs[16] (as in the Penn Medicine approach mentioned above), a stakeholder group of medical and pharmacy providers, as well as insurers with relevant expertise, could put together the list of products that would be sourced through Cost Plus and update the list as needed over time.[17]

While ordering and paying for outpatient products would be the responsibility of individual facilities, medical practices, and pharmacies, health plan reimbursement to outpatient providers would be based on the Cost Plus price for its generic products and the Civica Rx price for its biosimilar insulins as they come to market. Consumer cost or cost share would be based on Cost Plus and Civica Rx prices to encourage Vermont inpatient and outpatient medical providers to source from suppliers with the lowest cost. As the market adjusts to competition from Civica Rx and Cost Plus, product sourcing may change over time.

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[15] Pharmacies, clinics, and other purchasers could stock from another wholesaler, but in this scenario, participating health plans would pay based on the publicly known Cost Plus acquisition cost. This effectively means that dispensers would use other supply sources only if less expensive that Cost Plus.

[16] Cost Plus has over 2,000 drug products available.

[17] In all likelihood, Vermont medical systems and professionals would only use another supplier source with costs/prices lower than Cost Plus or Civica Rx to improve the margin provided by reimbursement based on Cost Plus and Civica Rx prices. For example, 340B product may be less costly than Cost Plus or Civica Rx. But the interplay with 340B would be part of the work of a group designing the overall generic supply system.

Managing the complexity of merging these disparate drug channels is a major endeavor requiring significant commitment and engagement. There are models for this in other states such as a similar arrangement that California has in place for its employee plan.

Interaction with Medicaid

An important question to consider for any potential cost containment approach is how it would interact with Vermont's Medicaid program.

Civica Rx does participate in the Medicaid drug rebate program. Their outpatient insulin would be shipped to participating pharmacies that agree to the price cap. Vermont pharmacies could be encouraged to participate as Vermont health plans would set claims payment rates for the insulin at the Civica Rx cap.

Cost Plus, on the other hand, does not participate in Medicaid. As such, no Cost Plus product is considered a Medicaid covered outpatient drug and thus eligible for federal matching dollars. Based on current Vermont and federal policy around the deep discount 340B program, there may be little impact on Medicaid because of a complex set of policies described briefly here.

Outpatient providers who participate in the 340B program will likely not use Cost Plus as a supplier because the 340B supply is likely to be less costly than Cost Plus and, because the manufacturers of those drugs have signed federal rebate agreements, the 340B supply are all Medicaid covered outpatient drugs.

Medicaid law requires that 340B providers not bill Medicaid Fee for Service (FFS) for 340B drugs dispensed to Medicaid enrollees or to only bill at the 340B acquisition cost (not prevailing market price). Additionally, Vermont does not allow 340B participating pharmacies (called contract pharmacies) to bill Medicaid. Finally, the Vermont Medicaid program must have processes in place to ensure that manufacturers are not billed rebates for drugs dispensed through the 340B program.[18]

To the extent that there are Medicaid enrollees served by providers other than 340B participating facilities, Vermont should pursue a waiver of federal covered outpatient drug rules to allow Medicaid to pay for drugs manufactured by Cost Plus when the reimbursement based on Cost Plus acquisition cost is less than what Medicaid would otherwise reimburse for a drug product. A waiver may be feasible under the Trump Administration, as it has already developed market-disrupting initiatives focused on branded and biosimilar drugs – including the new TrumpRx.gov website platform and the GENEROUS pilot project for Medicaid[19] – and the Administration continues to advance the Medicare price negotiation program. Currently, they have no initiative for generic drug

[18] There are 334 retail pharmacies in Vermont with over 900 contracts to serve the Medicaid patients of 340B outpatient service providers; there are 90 medical providers participating in 340B. This information is available at https://340bopais.hrsa.gov/

[19] The new GENEROUS pilot program would include only sole source (patent-protected) and innovator multi-source drugs (the branded original product that has generic competition) drugs. The Medicaid net cost would be equivalent to the average cost of a drug in European countries and executed through Medicaid supplemental rebates. The program is voluntary for both manufacturers and states Link: https://www.cms.gov/priorities/innovation/innovation-models/generous

products and thus a Vermont waiver would present a policy opportunity for both the State and the federal government.

Does the Program Need a Formulary?

The program envisaged in this report does not create a formulary; it does not require a list of covered and non-covered drug products. The program suggested here is a transparent rate-setting program for drugs supplied by either Cost Plus and/or insulins from Civica Rx. Medical professionals and entities that dispense or administer drugs can obtain their products from any supplier, but health plans will reimburse based on the Cost Plus wholesale cost (the cost to the wholesaler to buy a product from the manufacturer) or the Civica Rx insulin acquisition cost (the cost to the provider or facility to acquire the product). Stakeholder advisors would sort out which products yield the largest savings.

In such a model, hospitals order products through Civica Rx for inpatient products as needed and could use Cost Plus for products not available from Civica Rx. For outpatient services, it may be helpful to start with a limited list of products to be purchased through Cost Plus. A specific list of products with uniform upper payment limits from insurers based on the Cost Plus product price could facilitate smooth implementation as existing supplier contracts are adjusted and people experience working with Cost Plus wholesale services. The scope of the outpatient component can grow over time as the payers and purchasers assess the benefits and challenges of the system, as Cost Plus and Civica Rx grow, and as other suppliers begin to meet the moment.

Consolidating State Generic Drug Purchasing

Organizing and unifying the sourcing/supply of generic products via market disruptors could have a significant impact on generic drug spending in Vermont and be a model for other states. An initiative such as this would align incentives of the public and private payer and purchaser markets to use Cost Plus and Civica Rx as the preferred suppliers for generic and (as available) biosimilar products.

- The program is voluntary for all medical stakeholders with health plans providing incentive to participate via reimbursement based on Cost Plus and Civica Rx prices.
- There is no administrative burden for health plans to keep track of participating pharmacies and non-participating pharmacies for purposes of outpatient drug reimbursement.
- Unlike an exclusively mail-order program, this approach does not exclude Vermont retail pharmacies from participation.
- The financial incentives for professionals who dispense or administer medicines are aligned with cost reduction; there is no incentive to purchase from a source with prices higher than Cost Plus and Civica Rx.
- There is no incentive or meaningful benefit from trying to “game” the system. The business models and pricing of both Civica Rx and Cost Plus are transparent and open to anyone. Health plan reimbursement based on Cost Plus and Civica Rx

pricing is also transparent. If an entity can find a lower cost product, they can still bill up to the Cost Plus and Civica Rx insulin price.

Depending on the volume of Cost Plus products and Civica Rx insulin needed in Vermont, pharmacies may see a diminution in profit from each sale. In this scenario, health plans should consider increasing the dispensing fee to compensate.[20] The goal of a statewide generic purchasing program is that no market participant will be worse off than under the status quo.

Building a statewide generic drug cost containment system should not harm covered entities that participate in the deep discount federal 340B program. 340B provides substantial discounts on brand drugs at a minimum of 23%, while generic 340B discounts are 12%. These entities would bill and be reimbursed based on the Cost Plus and Civica Rx prices which could reduce, but not eliminate, the 340B profit margin.[21] Reduction in margin is perhaps a reason to limit the number of Cost Plus products included at the start of any program.

[20] Health plans could be required by law or rule to increase dispensing fees when the system is put in place.

[21] Here too, health plans could be required by rule or law to increase dispensing fees when the system is put in place.

Additional Opportunities to Reduce Costs for Generic Drugs

Companies like Civica Rx and Cost Plus offer a clear, market-oriented way to bring a supply of low-cost generic and biosimilar drugs directly into Vermont. In this section, we will discuss additional options for lowering costs for generic medications. These options are more policy-oriented and may require new laws.

Multi-Payer, Unified PBM Contracting

Vermont could consider organizing payers (particularly smaller payers) to contract with "alternative" PBMs that are willing to support payer innovation. Large PBMs are opaque and have contract templates that are not amenable to pharmacy benefit innovations that truly lower costs (rather than simply increasing rebate dollars alongside a concurrent increase in pharmacy spending). Their pharmacy payment rates are based on national pricing data and their lists of covered and excluded drugs are developed at the national level with little room for change or innovation, particularly for smaller health plans. Because of these factors, statewide innovation to lower the cost of drugs may require looking to smaller, more flexible PBMs. Important to note, however, that these PBMs may have less clout when negotiating with manufacturers because of issues of scale.

The Purchaser Business Group on Health (formerly the Pacific Business Group on Health) developed a PBM contract template for employers several years ago.[22] The template provisions place emphasis on clarity of terms, transparency, and account management, among other goals. There are 140 model provisions that, among others, specify PBM reporting, client audit rights, drug definitions, formulary development, and utilization management.

The State could facilitate the creation of an employer and insurer coalition to develop a model contract acceptable to all using the Purchaser Business Group template as a starting point. Then, the State could run a contract bidding process on behalf of the employer/insurer coalition to find a PBM that meets the needs of group members based on the group-designed contract. Bids would be reviewed by group members and a vendor selected by the group. It would be a uniform contract but executed separately by each employer or insurer; financial transactions would remain between the PBM vendor and each individual employer or insurer – no pooling of funds or payments across health plans. PBM fees, reporting requirements, formulary, and rebates would be the same for each payer contract. The State would have no role other than facilitating the stakeholder work and administering the bidding process. With a uniform contract, there could be one statewide pharmacy network serving all the contracts.

[22] Changing the game: groundbreaking drug benefit purchasing standards for large employers. Purchaser Business Group on Health. October 13, 2023. Link (accessed December 2025): https://www.pbgh.org/groundbreaking-drug-benefit-purchasing-standards/

Creating a Vermont payer coalition could streamline contracting, improve the quality of service provided, and, most importantly, give small- and medium-sized businesses control of pharmacy benefit management that is otherwise not available.

Nonprofit, State-Sponsored Wholesaler

There has been discussion in Vermont for several years about creating a nonprofit, State-administered (or State-sponsored) wholesaler to provide some or all of the state supply of medicines. Much has changed in the pharmaceutical market and the commercial wholesale industry since this idea first surfaced.

Particularly relevant to this policy option is the fact that Civica Rx and Cost Plus have their own wholesale supply operations for their own generic medicines. The very large federal 340B program – which provides medications at deep discounts to participating outpatient facilities – also has its own suppliers.

The wholesale medicine market has consolidated considerably; three wholesale companies supply 90% of the U.S. market (McKesson, Cencora [formerly Amerisource Bergen], and Cardinal Health); all three are in the top 15 of Fortune 500 companies. The roughly 10% of the market that is not captured by the big three focuses on specialty medicines supplied to small and independent pharmacies and hospitals. In contrast, the top three distributors have relationships with retail pharmacy chains, insurers, and PBMs. The major distributors also are moving into specialty drug distribution because the drug prices, and thus margins, are higher than the margins of high-volume generic drug products. Net margin for the largest distributors is generally estimated at 1% to 3% with some sources placing net margin estimates below that range.[23] [24] Movement of the largest distributors into the market niche of smaller wholesalers means more pressure on smaller wholesalers – a group that would include any proposed Vermont nonprofit wholesaler.

State policymakers should look more closely into whether an independent, nonprofit wholesaler in a very small state can benefit Vermont consumers and whether such a wholesaler is viable in the market today and, given market consolidation trends, over the long term.

A Vermont strategy that relies on Cost Plus or Civica Rx may not have a place for a State-sponsored wholesaler if that wholesaler cannot compete on cost or manage the administrative particulars of, say, ensuring pharmacy compliance with the limited price markups required by Civica Rx for its biosimilar insulins. If there is interest in a State-sponsored, nonprofit wholesaler, further analysis will be needed.

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[23] Drug distribution industry trends: insights into the pharmaceutical supply chain. Morningstar. May 16, 2025. Link (accessed December 2025): https://www.morningstar.com/business/insights/blog/markets/drug-distribution-industry-trends

[24] How Much Do Pharmaceutical Wholesalers Make? - Profit & Revenue Analysis Link (accessed December 2025): https://medx.it.com/understanding-how-much-do-pharmaceutical-wholesalers-make

Discount Cards for Insured & Uninsured

ArrayRx, a nonprofit, government operation formed through a partnership between Oregon and Washington State, offers a drug discount card program as an alternative to similar for-profit options in the marketplace. ArrayRx is unique in its program design, governed by a steering committee with public-sector pharmacy expertise, with concern for consumer privacy protections and sustainability of independent pharmacies. ArrayRx is open to all state entities for any of the full range of services offered, including services typically provided to health plans by pharmacy benefit managers. It also has a discount card that Nevada and Connecticut sponsor for their uninsured population and that Ohio sponsors for its Workers Compensation program.[25] As of January 2026, the State of Vermont Office of the State Treasurer is seeking enabling legislation to grant the Treasurer's office authority to join the multi-state collaborative for Vermont participation in the ArrayRx discount card program.

A for-profit drug discount card called VermontRX, was made available in Vermont many years ago for Vermonters who do not use insurance to purchase retail pharmaceuticals.[26] This card operates in many other states as well, however it does not seem to be widely used across Vermont and may currently be inactive. VermontRx is similar in concept to the national GoodRx discount program.

[25] Array Rx. Link (accessed December 2025): https://www.arrayrxsolutions.com/

[26] Vermont RX card. Link (accessed December 2025): https://vermontrxcard.com/

Approaches to Branded Drugs & Biologics

Unlike the generic market, the path for Vermont is less clear when it comes to brand name drugs. The branded pharmaceutical market shows signs of innovation, but these innovations are in their early stages, and their impact cannot yet be known. Amid significant market change, it may be difficult to craft effective or operational cost containment strategies for Vermont.

The variety of strategic business models and policies that deserve monitoring – including direct-to-consumer sales, statewide upper payment limits, manufacturer rebates, and the possible extension of the Medicare Maximum Fair Price to all consumers – are quite varied and are described in the following sections.

Direct-to-Consumer Sales

Direct-to-Consumer Sales is the business model developed by the pharmaceutical manufacturing industry for most of the newly implemented and forthcoming programs.[27] For example, brand name insulin makers rolled back their prices in 2024 and set up "Pharm to Table" – or direct-to-consumer – sales that are now a significant trend in the industry.

Some of these existing or announced programs ship directly to consumers, who pay cash and thus do not involve their health insurance in the purchase.[28] Reimbursement may be negotiated with the health insurer separately in some circumstances. Some models (although a seemingly small number thus far) use pharmacy distribution and, like Civica Rx, require pharmacies to limit the markup on their products. Using pharmacy distribution allows the point-of-sale claim to be sent to the insurer from the pharmacy. This spares the consumer the burden of seeking health plan reimbursement for the purchase themselves. It appears that these programs do not include all of a manufacturer's products (although that may change as the models evolve).[29] The Direct-to-Consumer model circumvents the health insurer and pharmacy benefit manager (PBM) limitations and negotiations such as rebates, prior authorization, and formulary management, resulting in more revenue to the pharmaceutical manufacturer.

Statewide Upper Payment Limits

Vermont should continue to watch the evolution of state-based prescription drug affordability boards (PDABs). Their role may grow considerably as the expected savings from Medicare price negotiation decrease from what was originally anticipated (see the section below). There are four states that have boards with the authority to establish

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[27] Pharma companies announce direct-to-consumer sales and price cuts in US. Reuters. October 13, 2025. Link (accessed December 2025): https://www.reuters.com/business/healthcare-pharmaceuticals/big-pharma-firms-announce-direct-to-consumer-sales-price-cuts-us-2025-10-13/

[28] Whether individuals can seek reimbursement from their insurer for cash payments most likely depends on the health plan and the product. It may be good to understand the reimbursement policies of Vermont health plans.

[29] It remains to be seen how pharmacies with react to drug dispensing moving to on-line service that will likely be managed by large corporations.

statewide upper payment limits for certain high-cost drugs.[30] Colorado just established its first upper payment limit. Other states will follow, particularly as Medicare becomes less effective at addressing the most expensive branded drugs. Vermont's preliminary report published under Act 134 in January 2025 describes in more detail the experiences of states that have developed PDABs[31] including the estimated financial investment and staffing resources required to establish and maintain PDABs.

Vermont should still expect to face challenges setting upper payment limits due to the market size issues discussed earlier in this report. However, should market disruption remain purely voluntary for manufacturers and limited to only a few of those manufacturers' drugs, the need for state action may continue to grow.

For branded products, Vermont should continue to pay attention to the states with upper payment limit authority to see the effect of those limits – particularly amid all the ongoing changes in the branded market and the growth of the number of drugs exempt from Medicare price negotiation.

Rebate Pass-Through

Rebate pass-through is an idea that has been promoted by states. Several states have legislation that requires PBMs to pass back or pass through some percentage of manufacturer rebates. In this model, some or all of the rebate amount gets passed to insurers, helping to lower their overall spending. Rebates are often paid up to six months after the transaction and paid in bulk, leading to complexity in practical terms. Consumers benefit if the law requires insurers to apply the rebate to consumer co-pays and out-of-pocket costs. West Virginia and Florida have rebate-pass-through laws that require 100% of the negotiated rebate be passed through to the health plan. West Virginia has estimated that the rebate pass-through has reduced premium increases by an average of 52%.[32]

Rebate pass-through has also entered the commercial market, though in a different form than that put forth by the states. At least one national insurer has joined the mix of entities working on drug manufacturer rebates. Cigna and its PBM, Express Scripts, recently announced the "end of rebates" in all its commercial fully insured health plans in 2027 and all health plans, including employer plans, in 2028. Instead, the company/PBM will negotiate with manufacturers for lower net costs for Cigna health plans and the PBM. Enrollee cost sharing based on Cigna's net cost will count toward the deductible. Public details are sparse as of the writing of this report, but regardless of how Cigna frames their policy, it seems likely to be operationalized via rebate since pharmacies purchase products at close to list price and must be reimbursed for their costs. If the Cigna policy

[30] Colorado, Maryland, Minnesota, and Washington.

[31] Preliminary report on implementing a Vermont prescription drug cost regulation program. Green Mountain Care Board. January 15, 2025. Link (last accessed January 7, 2026): https://gmcboard.vermont.gov/sites/gmcb/files/documents/Act134_Prelim_Rpt_FINAL_1-15-2025.pdf

[32] Bell, A. PBM rebate law leads to dramatic premium reductions in West Virginia. BenefitsPro. March 5, 2025. Link (accessed December 2025): https://www.benefitspro.com/2025/03/05/pbm-rebate-law-leads-to-dramatic-premium-reductions-in-west-virginia/

is implemented via rebates, the policy is more aligned with the rebate pass-through programs of Florida, West Virginia, and other models described in Appendix B.

Alternatively, Cigna/Express Scripts may adapt the Medicare negotiation model, which all manufacturers, insurers, and PBMs will have to implement to participate in Medicare. The negotiated price – or Medicare Maximum Fair Price – will be in the PBM pharmacy IT system and will determine what the enrollee pays the pharmacy and what the pharmacy bills Medicare Parts D and B. Because the pharmacy will have paid the market price to stock the drug, the manufacturer will reimburse the pharmacy the difference between the Medicare Maximum Fair Price and the pharmacy's cost of acquisition.[33] It is a very complex process, but the system must be in place and running in January 2026. Once established, this approach may become the standard model for lowering costs for the consumer at the point of service. If it does become an operational standard, it follows that the simplest approach may be for manufacturers to lower prices and for states to ban rebates for manufacturers who have lowered their price to the MFP; the whole system can revert to normal wholesale distribution at the new lower price.

Direct-to-Consumer Aggregator Web Portals

An increasingly popular policy response, direct-to-consumer aggregator web portals direct consumers to the website of drug manufacturers with direct-to-consumer or other patient-focused discount price programs. The Trump administration and the brand industry trade association, PhRMA, will each establish such a portal in 2026. Broad knowledge of these direct-to-consumer and other programs should increase access to a few more brand products across the country. While Eli Lilly's Lilly Direct and Novo Nordisk's Novo Care are already operational, most of these proposed initiatives are expected to go live sometime in 2026.[34]

Medicare Maximum Fair Price (MFP)

Medicare MFP has created two distinct market trends that will further confound, confuse and muddle state cost containment efforts for branded drugs. The first trend is toward greater competition for drugs facing patent expiry and other legal market protections. For many years now, companies whose product is on the verge of facing competition have taken legal action against potential competitors to delay their entry into the market by months or years.

Drugs are only subject to Medicare price negotiation if they have no competition at the end of federal innovator drug market protections. In other words, delaying market competition puts a product in the potential crosshairs of negotiation. Competition is

[33] The reimbursement will not be dollar for dollar, but paying average market benchmark, (national or regional) that will not necessarily be equal to a pharmacy's actual cost to buy/stock the drug.

[34] For more information on specific companies or direct to consumer approaches, see this comprehensive analysis at Cost Curve News (https://www.costcurvenews.com/2025/03/11/looking-at-the-pioneers-in-the-nascent-pharm-to-table-movement/) or this piece about the insurer/PBM approach at Cigna (https://www.healthcarefinancenews.com/news/cignas-evernorth-end-pharmacy-benefit-manager-drug-rebates)

generally thought to be a good way to lower prices (or at least net prices after competitive rebates).

Due to Medicare negotiation, the trend toward greater competition in the brand market may persist, but a change to program law may substantially lessen the savings that can be derived from greater competition and may ultimately undermine the market reach of the program – and thus program savings. This recent change now completely exempts any drug with approval for rare disease treatment from Medicare negotiation. Prior to the 2025 change, the law exempted a rare disease drug[35] – also known as an "orphan" drug – from negotiation if it was approved for only one indication and that indication was a rare disease.

Treatments for rare diseases are typically quite costly – sometimes millions of dollars for a treatment. Rare disease drugs typically gain additional treatment approvals over time, expanding the patient population while keeping the original rare disease price. This is problematic. For example, Keytruda, which was until recently the best-selling drug in the world, started with approval to treat one rare disease: advanced melanoma. It has subsequently been approved to treat more than a dozen illnesses – some rare and some common. Humira, the best-selling drug in the world before Keytruda, was approved to treat many conditions, a few of which are rare diseases.[36]

Orphan drug development comes with many benefits that lower research and development costs and other pre- and post-market costs for drug companies. Additionally, rare disease products have very little, if any, pressure on pricing. The extremely lucrative orphan drug space had already become the focus of drug development and an interest of drug manufacturers as a business model before Medicare negotiation was implemented. The industry was persistent in advocating for the law to greatly expand the number of drugs that will be exempt from Medicare Maximum Fair Price rules. Thus, in 2025 the law expanded the exemption such that more drugs will be exempted from negotiation than will be subject to negotiation under Medicare Maximum Fair Price rules.[37]

The result of this change is that there is little chance Medicare negotiation will deliver on the promise of cost reduction. Medicare will not be able to manage the skyrocketing price of pharmaceuticals as the products come to market and expand the licensed indications. The Congressional Budget Office estimates that the 2025 change will reduce savings by $8.8 billion dollars over the next ten years. [38]

Policy makers in several states have contemplated making the negotiated Medicare price of a product the statewide upper payment limit for that product in the state. This may no longer be a solid strategy because of foreseeable trends:

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[35] Rare disease is defined as one that affects fewer than 200,000 people. An orphan drug is a rare disease drug.

[36] For more on these drugs see https://www.keytruda.com/ and https://www.humira.com/

[37] Horvath, J. Horvath orphan drug report 2023. Link (accessed December 2025): https://drive.google.com/file/d/1GWpSHS_iRYVGTkNHy5i4fQpIld6-fXCZ/view?usp=drive_link

[38] Revised estimate of changes under the 2025 reconciliation act for exemptions from Medicare price negotiations for orphan drugs. Congressional Budget Office. October 20, 2025. Link (accessed December 2025): https://www.cbo.gov/publication/61818

- As rare disease product launches outnumber non-rare disease treatments, Medicare will be negotiating to lower the cost of fewer expensive products.
- Medicare prices established for 2026 indicate that the negotiated price is roughly equivalent to the current level of price concessions already in the market to PBMs, healthcare providers, and facilities and is less than prices in other countries.[39]
- The lower prices offered in the manufacturer direct-to-consumer trend will likely also be roughly equivalent to the rebates/price concessions the manufacturer already offers to insurers.

Using the Medicare MFP is not likely to produce much greater savings for costly drugs beyond what will soon be available in the market to all consumers via new direct-to-consumer efforts, although Medicare will soon be negotiating 20 drugs a year, which will add up over time.

In addition, as this report was being written, CMS announced two additional pilot programs focused on brand name drugs that will benchmark what Medicare will pay for Part D and Part B drugs to the international prices for those drugs. At the same time, the Trump Administration announced a separate deal with a group of drug manufacturers for lower prices for Medicaid, Medicare, and the previously mentioned TrumpRx web portal. The prices announced for this deal are lower than those to be implemented in 2026 for the drugs selected for the first round of Medicare price negotiation. It is unclear how these new programs will interact with each other or the existing MFP program.

For any state to adopt the MFP, it will need to work through a host of implementation complexities, which are described in Appendix B. These complexities make this policy solution less attractive and likely an inefficient way to lower branded drug costs. This assessment may change due to ongoing market disruption and should continue to be monitored.

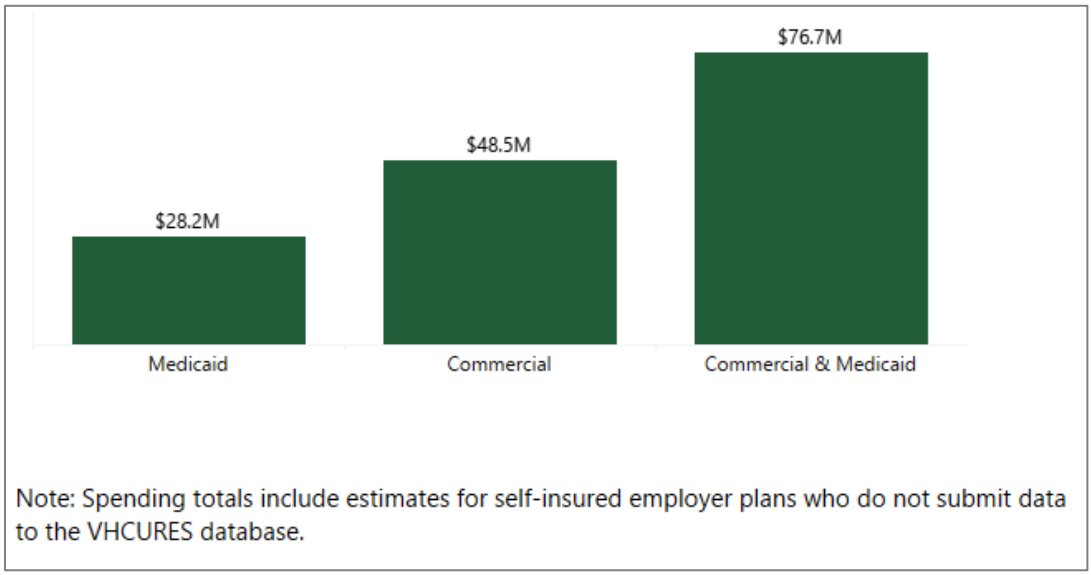
The section below provides an analysis of potential savings for Vermont should the MFP for the first 10 CMS-negotiated drugs be extended to all residents.

Analysis of Medicare Maximum Fair Pricing

We analyzed current spending for commercial and Medicaid populations for extending CMS negotiated prices to the first 10 CMS-negotiated drugs and found that 2023 pharmacy claims spending in Vermont for those 10 drugs showed a total of $76.7 million in spending.

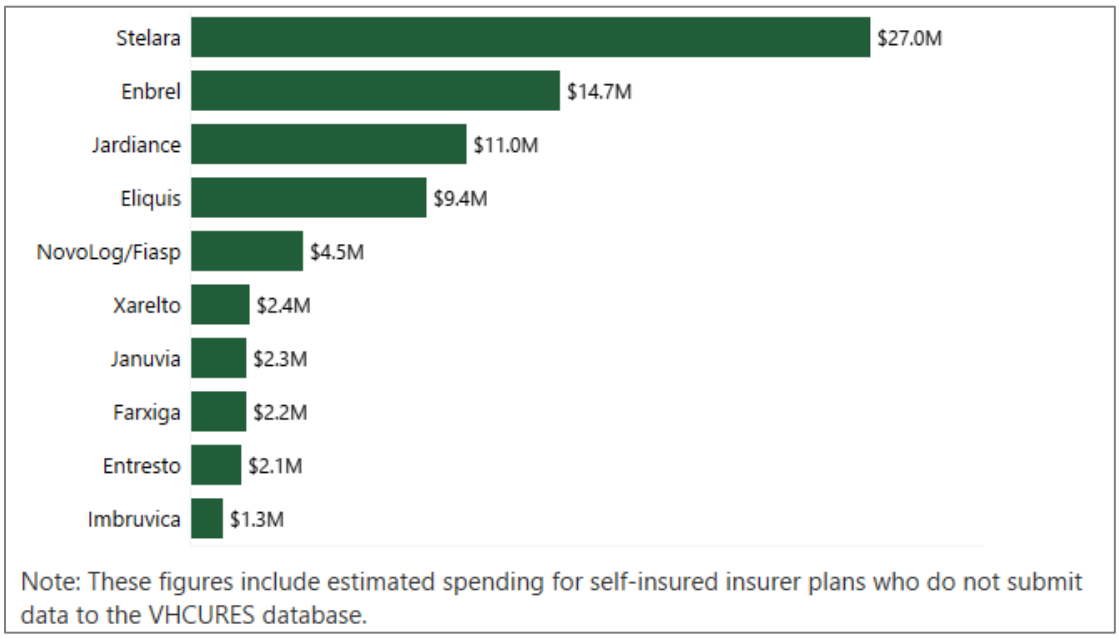
[39] Laurent, A. US drug wholesalers: analysis of the big three's market control. Intuition Labs. January 4, 2026. Link (accessed December 2025): https://intuitionlabs.ai/articles/drug-wholesaler-market-concentration, and Tevis, Delaney, et.al. How Medicare negotiated prices compare to other countries. Peterson-KFF Health System Tracker. December 19, 2024. Link (accessed in December 2025):https://www.healthsystemtracker.org/brief/how-medicare-negotiated-drug-prices-compare-to-other-countries/#Comparison%20of%20list%20prices,%20Big%20Four%20prices,%20and%20Medicare%20negotiated%20drug%20prices%20per%2030-day%20supply,%20U.S.%20dollars,%202024.

Figure 2. Total Pharmacy Claims Spending for the 10 MFP Drugs by Payer Type (2023)



In 2023, Medicaid and commercial plan spending on the 10 MFP drugs was heavily concentrated in a few high-cost drugs. Stelara accounted for $27.0 million in total spending — split between $18.7 million in commercial claims (69%) and $8.3 million in Medicaid — more than any other MFP drug across the two payer types. Enbrel had the second-highest spending, with $14.7 million in total spending, primarily driven by commercial payers (77% of total).

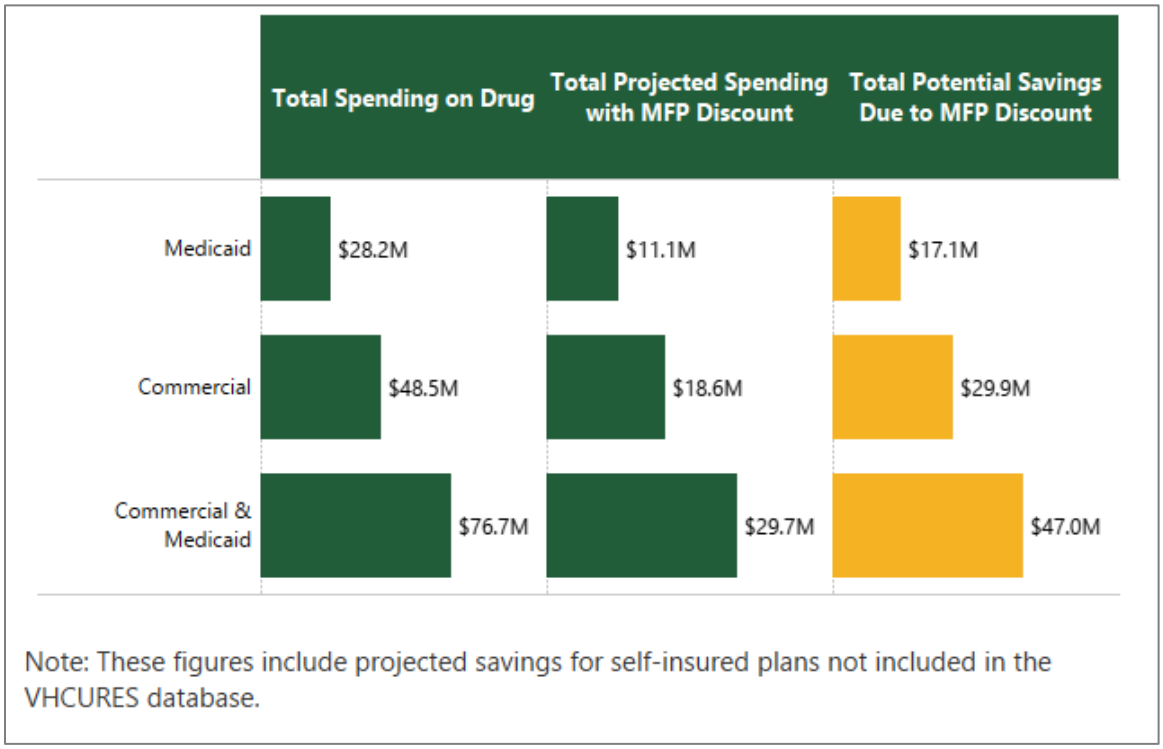
Figure 3. Total Pharmacy Claims Spending for the MFP Drugs in 2023, Commercial & Medicaid



MFP-negotiated prices would potentially deliver an estimated total of $47.0 million in savings for Medicaid and commercially insured patients. Approximately $29.9 million in savings would accrue for commercial patients, with an additional $17.1 million for

Medicaid. MFP discounts could cut total spending on these drugs by more than 60% from 2023 prices, with potentially greater savings over time as prices are held steady.

Figure 4. Projected Savings for MFP Drugs (2023) by Payer Type



Explore the full Medicare Maximum Fair Price analysis here[40].

[40] GMCB prescription drug affordability program: Medicare Maximum Fair Price pricing analysis. Green Mountain Care Board. Undated. Link: https://public.tableau.com/app/profile/onpointhealthdata/viz/VTGMCBMedicareMFPPharmacyAnalysis/MFP

Conclusion

Since 1999, when the first multi-state effort at drug cost containment was launched (with Vermont as a participant), the pharmaceutical market has undergone significant changes, often to the detriment of consumers. Recently, however, there have been changes that are more positive for consumers. The most promising developments are occurring in the generic market.

There are several significant voluntary market-based strategies that may lower the costs of generic drugs for patients, providers, and payers. For branded drugs, a more regulatory approach to cost containment may be feasible once more is known about the effectiveness of the Medicare drug negotiation program (given the extensive orphan drug exception) as well as about how the implementation of upper payment limits play out in larger states. New programs announced by CMS and the Trump Administration should also be monitored, though some may not serve as long-term solutions due to how they are structured, as they may not last beyond this administration.

Savings on generic versions of very expensive drugs are often themselves quite expensive. This is because, to some extent, the generic drug will "shadow-price" the expensive brand name product, bringing the price down while still keeping the cost to the consumer very high. By contrast, Cost Plus Drug Company marks up from the cost of production rather than marking down from the price of the brand product, so savings could be quite substantial for some products when accessed through newer manufacturers that are committed to a different business model that focuses on affordability and not merely price. There are fewer ways for a state to obtain savings on branded drugs, but options that exist can provide significant savings.

The following policy recommendations are offered for consideration.

Vermont should leverage companies such as Civica Rx and Cost Plus Drug Company as suppliers for lower cost prescription drugs. This strategy will require a coalition of willing partners across the industry in Vermont including hospitals, payers, pharmacies, and state agencies.

Vermont should continue to monitor the progress of Prescription Drug Affordability Boards (PDABs) in other states and learn from those experiences. These boards are costly to administer (based on available information from other states that have PDABs in place) – averaging more than one million dollars annually, and with several dedicated staffed FTEs[41] – but their role may grow considerably if the savings realized from the Medicare Maximum Fair Price negotiation program is less than originally anticipated.

Vermont should consider the distribution of pharmacy discount cards to Vermonters through the non-profit multi-state partnership organization ArrayRx. Although there is already a discount card available to Vermonters called VermontRx, it is not well-utilized

[41] Preliminary report on implementing a Vermont prescription drug cost regulation program. Green Mountain Care Board. January 15, 2025. Link (last accessed January 7, 2026): https://gmcboard.vermont.gov/sites/gmcb/files/documents/Act134_Prelim_Rpt_FINAL_1-15-2025.pdf

across Vermont and does not offer the kinds of benefits, protections and savings that are offered through ArrayRx.

Vermont should establish an advisory committee of people with expertise in the pharmaceutical supply chain, as well as payer and PBM services and operations – to continue the effort to review all the newly available options to lowering prescription drug costs for all parts of the pharmaceutical market in Vermont.

Vermont should develop a comprehensive prescription drug price transparency program strategy that strengthens transparency laws and brings together current reporting requirements already in place with new data reporting requirements from across the health care marketplace.[42] Act 134 of 2024 enabled the GMCB to produce a variety of meaningful analyses using currently available sources of prescription drug data. These dashboards are available on the GMCB website[43] and include repricing analyses to demonstrate the potential for cost savings, as well as analyses of highest-spending and most-utilized prescription drugs from pharmacy claims in Vermont. Several other states – such as, Maine, Minnesota, and Oregon – have established robust prescription drug price transparency programs. These programs enable improved and on-going prescription drug pricing visibility, monitoring and evaluation.

[42] Drug price transparency toolkit. National Academy for State Health Policy. December 5, 2025. Link: https://nashp.org/drug-price-transparency-toolkit/

[43] Prescription drug affordability in Vermont. Green Mountain Care Board. Undated. Link: https://gmcboard.vermont.gov/prescriptiondrugaffordability

Appendix A. Prescription Drug Market in Vermont

The following sections discuss the pharmaceutical market in Vermont in detail, as well as steps that have already been taken by the State to lower prescription drug spending.

Regulatory Levers Implemented in 2025

18 V.S.A. § 9406 (Act 55 of 2025 (H.266)) requires each Vermont hospital participating in the 340B drug pricing program to submit a report about their participation to the Green Mountain Care Board (GMCB) annually by January 31. This is a new annual report that will be released for the first time in 2026. Vermont hospital 340B program participation reporting is one lever through which the State may facilitate continuous monitoring and improvement of health system performance by means of data transparency to improve the quality and affordability of care. This transparency requirement was modeled on recent efforts in Colorado and Maine that shed light on the opaque 340B program.

In addition, Act 55 restricts Vermont hospitals (except those designated as independent Critical Access Hospitals) from billing insurers more than 120% of a drug's Average Sales Price (ASP) for drugs administered in the facility. This reform complements the insurer reporting mandated by Act 193[44], extending cost oversight to hospital-administered drugs and supporting broader GMCB efforts to promote fair, transparent pricing across care settings. These efforts are directed at drugs delivered via hospital channels, rather than pharmaceutical purchases by consumers at retail pharmacies.

Vermont Demographics Implicate New Policy Choices

Approaches to statewide drug cost containment can be either regulatory or market based. Designing a solution that addresses costs to consumers, purchasers (pharmacies and a variety of other facilities), and health insurers is a complex task, and any solution may prove difficult to implement. However, there are strategies that blend both market-based and regulatory approaches that are worth consideration.

In the context of a very large global pharmaceutical market, Vermont's small population limits the type and scope of policy changes that can effectively constrain drug costs for patients, payers, and purchasers. Because of its unique demographics, it is unlikely that there are any "off the shelf" cost-containment solutions – either market-based or regulatory – that can be applied directly to Vermont. Strategies from other states have been and continue to be explored for potential adoption in Vermont; however, these strategies would likely need to be tailored to the State's specific context.

There are approximately 648,000 Vermonters; the State ranks 49th in population among U.S. states. Even if all payers, purchasers, and consumers were aggregated into one contracting or buying unit, Vermont would remain a tiny market. Market size is important in commercial markets for goods and services, because the seller's price is generally based on volume purchased and the extent to which the sale increases the seller's share of the market relative to a competitor. In a market dominated by global pharmaceutical

[44] 18 V.S.A. § 4636 (Act 193) requires that large commercial insurers submit data to GMCB annually to publish a report on the effect of pharmaceutical spending on commercial insurance premiums.

corporations and a concentrated group of national wholesalers, the scale of the Vermont market is, unfortunately, not a driver of global revenue or even U.S. market share. As such, a large company could exit the Vermont market with minimal financial impact if a regulatory policy is not acceptable on principle.

To maximize the potential for success, Vermont's policy approach to lowering the cost of drugs should be specific to the state's market conditions and demographics. To that point, sources of healthcare coverage are also important in crafting policy approaches.

Coverage statistics for Vermont:[45]

- Nearly one-fourth, or 25% of Vermonters, receive coverage through Medicaid.
- A quarter, or 25% of Vermonters, are covered by Medicare.
- A very small amount (2%) receive coverage through the military.
- The uninsured account for 3% of the population.
- The rest of the population (52%) has employer or individual market coverage.
  - 88% of this group have employer-related coverage.
  - 11% purchase their health insurance coverage directly.

The three dominant insurers in Vermont's commercial health insurance market are Blue Cross Blue Shield of Vermont, Cigna, and the MVP Health Plan.

Other limitations to consider:

If the Vermont policy approach addresses only those with commercial coverage and/or employer plans, the market will be smaller than the total covered lives of many U.S. employers and provide very little market leverage over very large wholesalers or global corporations.

Policies that require drug manufacturers to discount products are likely to provoke legal challenge based on the U.S. Constitution's Commerce Clause. In brief, the Commerce Clause specifies that the federal government, not states, regulates interstate commerce. There is abundant caselaw criteria on what determines a state violation of the Commerce Clause. Mandatory in-state market participation with state-imposed sale price limits placed on out-of-state companies is one set of policies that may result in a challenge based on what's called the "dormant" Commerce Clause. This is an instance where state law may be considered an undue burden on interstate commerce.

To avoid a Commerce Clause challenge, the clearest way forward is to make participation in the cost-control program voluntary for suppliers and entities not licensed or regulated by the State and mandatory for state-licensed or regulated entities who rely on out-of-state suppliers. This is where market size is important to policy.

Because of the interplay among market business models, Commerce Clause limitations, and Vermont's scale, Vermont should consider a drug cost control policy that consolidates

[45] 2025 Vermont Household Health Insurance Survey. Vermont Department of Health. May 2025. https://www.healthvermont.gov/sites/default/files/document/hsi-hhis-2025-report.pdf

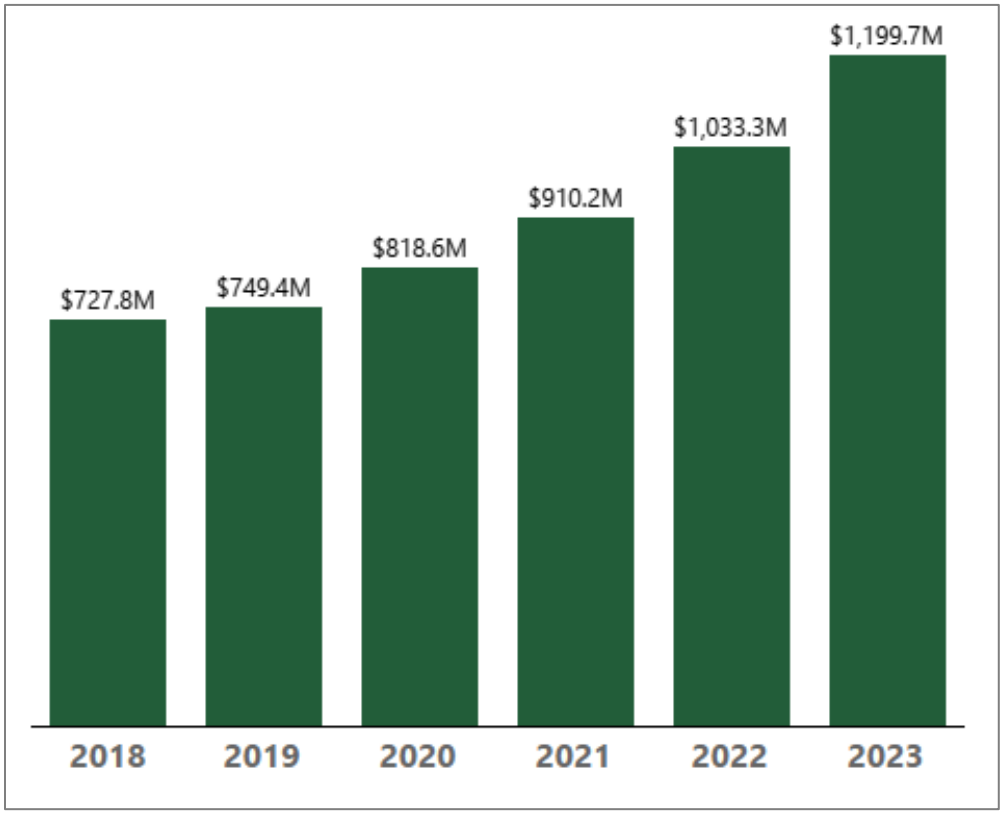
all, or almost all, State payers and purchasers. Even then, it will remain a very small market. In addition to maximizing potential leverage, establishing a market that includes all payers and direct purchasers could simplify the implementation of any cost control measure. Creating a voluntary public and private purchaser and payer coalition requires conversation and collaboration led by the State. The policy generally should be beneficial to all participants in some way. The good news is that Vermont's small size enables market-based, voluntary policy for public and private sectors that would be very difficult to create in a larger state.

Retail Pharmacy Spending in Vermont

Trends in Spending

Between 2018 and 2023, spending on retail pharmacy claims in Vermont's APCD, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), across all payer types showed a consistent and substantial upward trend (**Figure A1**). Starting at $727.8 million in 2018, expenditures rose each year, reaching $1.2 billion in 2023. This represents a total increase of nearly 65% over six years, with the most significant year-over-year jump occurring between 2022 and 2023.

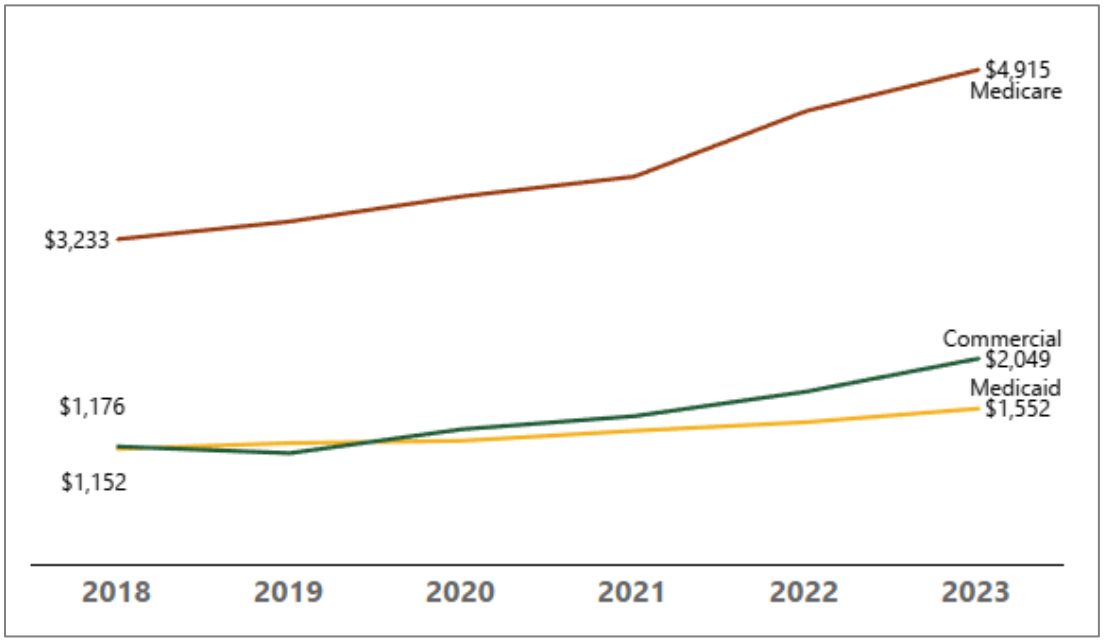
Figure A1. Trends in Spending for Retail Pharmacy Claims in VHCURES, All Payer Types (2018-2023)



In 2023, both total aggregate pharmacy claims spending and spending per member per year (PMPY) were highest among the Medicare population and lowest among the Medicaid population (**Figure A2**). Medicare patients experienced the greatest increase in

PMPY pharmacy spending, with PMPY spending climbing from $3,233 to $4,915, an increase of $1,682 (more than 50%) during the 5-year period. It is important to note that traditional Medicare does not cover retail pharmaceutical costs and patients must either pay out of pocket or purchase a Part D retail pharmaceutical drug coverage plan from a commercial health insurer contracted with CMS. Patients with commercial insurance ($2,049 PMPY) and Medicaid ($1,552 PMPY) had lower PMPY spending than Medicare patients in 2023.

Figure A2. Trends in PMPY Spending for Pharmacy Claims in VHCURES (2018-2023)



Brand & Generic Spending

In 2023, generics made up more than 82% of all prescriptions filled across payer types, yet almost 86% of total retail pharmacy spending in Vermont was attributed to brand-name drugs (**Figure A3** and **Figure A4)**. This distribution of costs is typical nationally. Medicaid members had the highest share of brand-name drug fills (21.7%), whereas Medicare members had the lowest (14.7%). Spending patterns reflected this, with 88.6% of drug spend on brand drugs for Medicaid and 83.5% for Medicare.

Figure A3. Prescriptions Filled: % of Brand & Generic Drugs by Payer Type (2023)

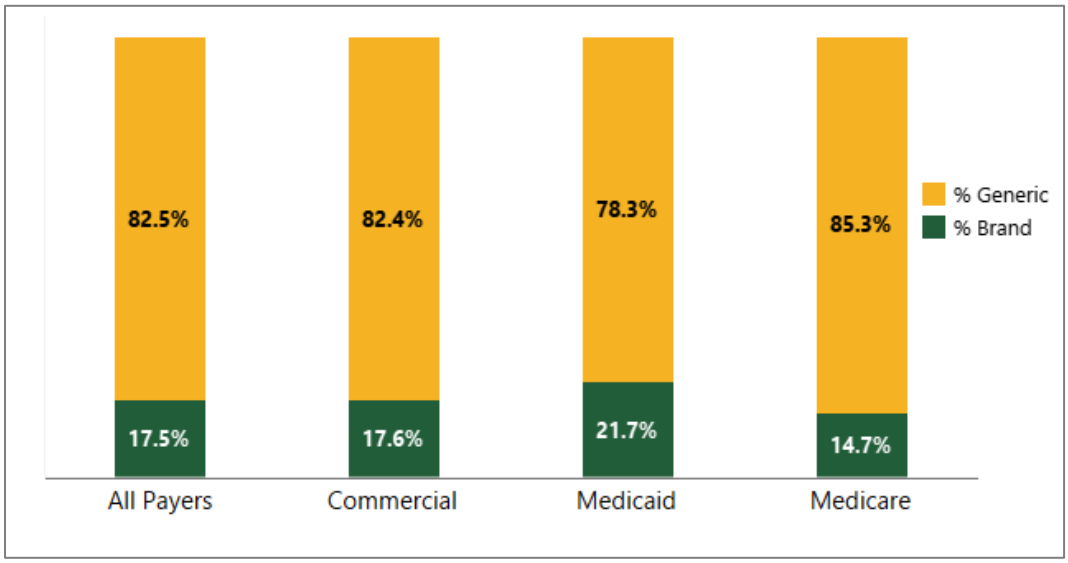
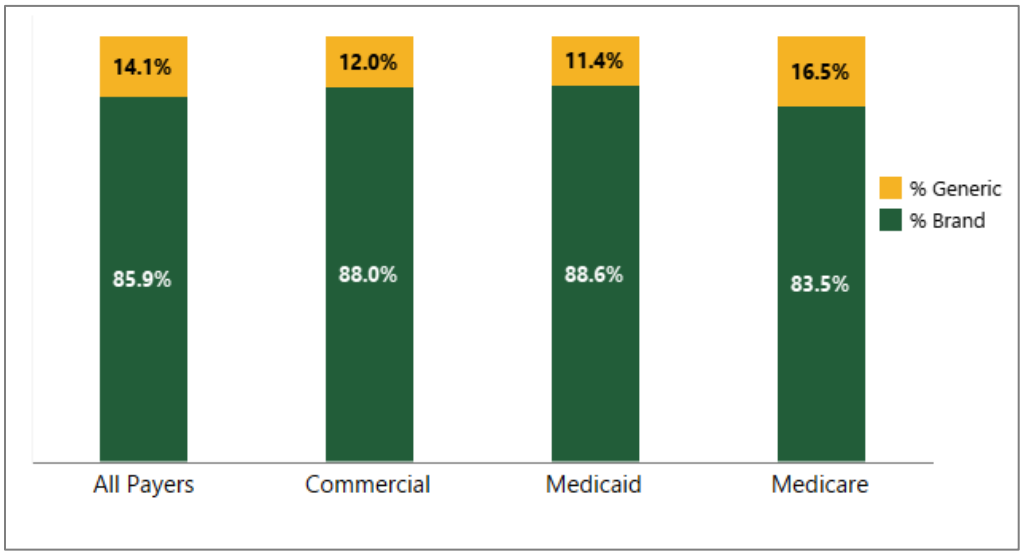


Figure A4. Pharmacy Spending: % of Brand & Generic Drugs by Payer Type (2023)



Explore details on overall trends in prescription drug spending in Vermont here[46].

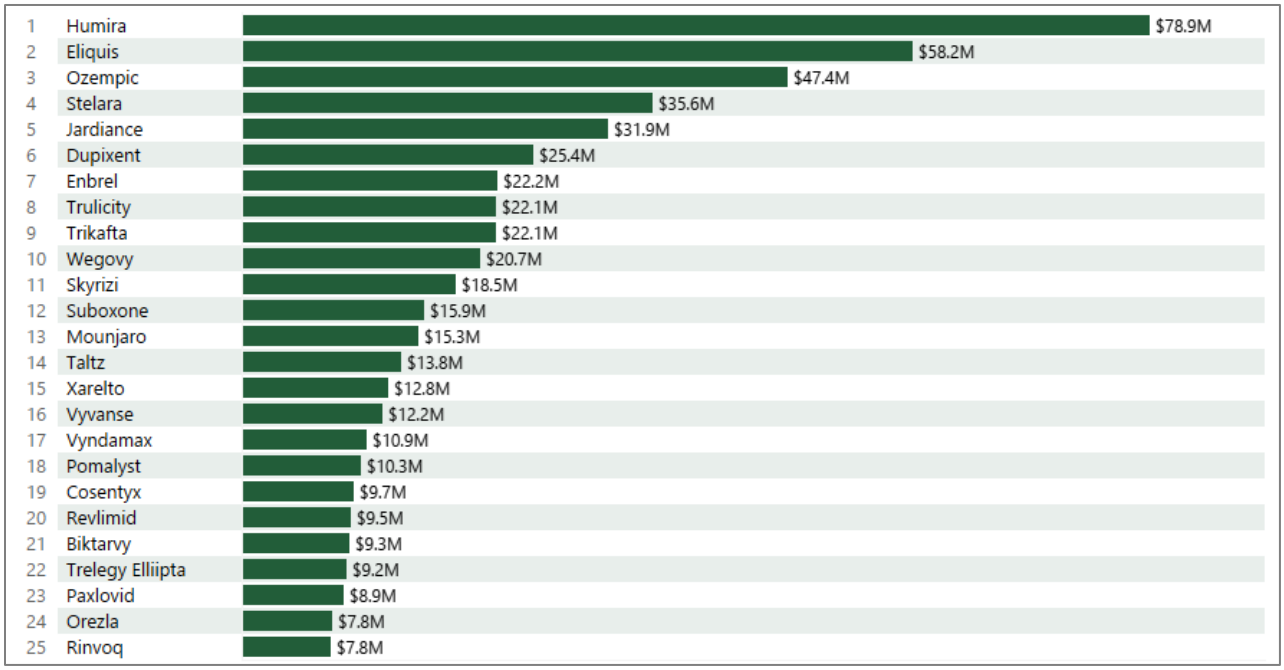
Highest Cost & Most Utilized Drugs

Across all payers, 2024 pharmacy claims spending was concentrated in a small group of high-cost brand-name drugs (**Figure A5**). Humira led across all payer types, totaling nearly $79 million, followed by biologics like Stelara, Dupixent, Enbrel, and Skyrizi, which reflected the high cost of treating chronic inflammatory diseases.

[46] GMCB prescription drug affordability program: Retail pharmacy spending analysis. Green Mountain Care Board. Undated. Link: https://public.tableau.com/app/profile/onpointhealthdata/viz/VTGMCBPharmacyAnalysis/CPD

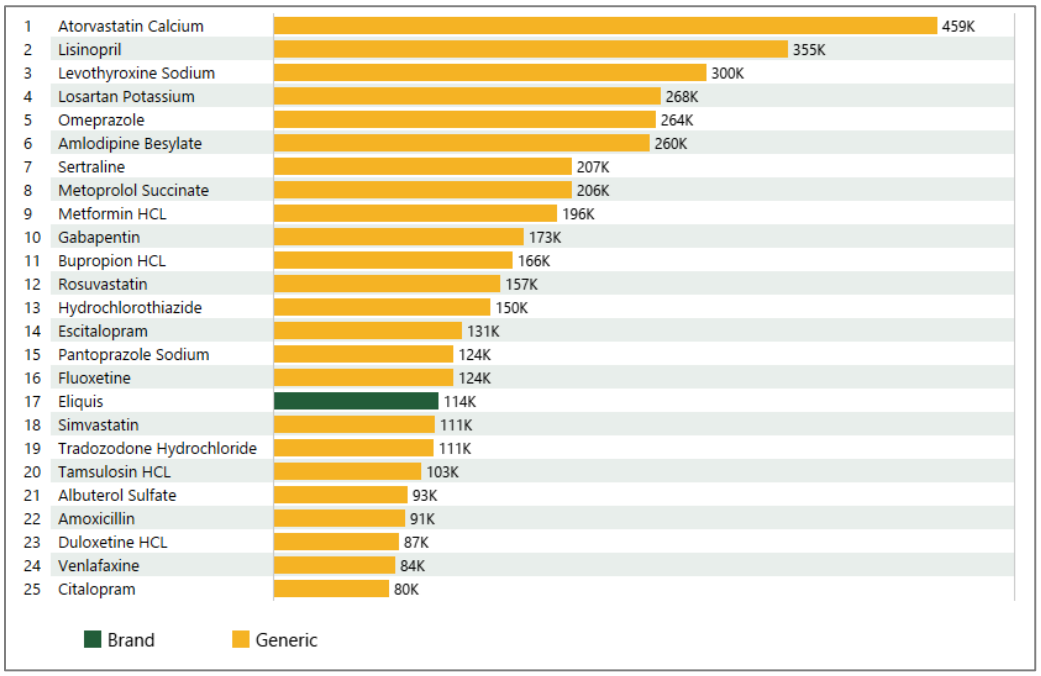
A second major finding is the rapid rise of extremely high-cost GLP-1 receptor agonists—Ozempic, Trulicity, Mounjaro, and Wegovy— that dominated commercial and Medicare spending and are reshaping pharmacy spending overall.

Figure A5. 25 Drugs with the Highest Total Pharmacy Claims Spending in 2024, All Payers



Across all payers, 2024 pharmacy utilization – measured in 30-day equivalents, or a 30-day supply of the prescription – was overwhelmingly driven by generic drugs (**Figure A6**). The most widely used medications included cardiovascular therapies such as Atorvastatin Calcium, Lisinopril, Losartan Potassium, Amlodipine Beylate, and Metoprolol Succinate, reflecting the continued prevalence of chronic heart conditions. Mental health medications ranked prominently as well, with high volumes for Sertraline, Bupropion, Escitalopram, and Fluoxetine. Additionally, gastrointestinal and metabolic treatments like Omeprazole, Pantoprazole, and Metformin showed broad, cross-population use.

Figure A6. 25 Drugs with the Highest Total Pharmacy Claims Usage (30-Day Equivalents) in 2024, All Payers



Explore details on the highest spend and most utilized drugs here[47].

[47] GMCB prescription drug affordability program: analysis on retail pharmacy drugs with highest spending and utilization. Green Mountain Care Board. Undated. Link: https://public.tableau.com/app/profile/onpointhealthdata/viz/VTGMCBPharmacyTop25/Top25

Appendix B. Drug Cost Containment Efforts in Other States

This appendix provides descriptions of additional approaches that have been undertaken by other states, including some small states, trying to contain the cost of prescription drugs. While not as appropriate for Vermont as those mentioned in the body of this report, these approaches may be worth considering in the future.

Wholesale Prescription Drug Importation from Canada

Currently, five states (Colorado, Florida, Maine, New Mexico, and Vermont)[48] have laws enabling the wholesale importation of prescription drugs from Canada, but federal approval of specific programs is required before importation can begin. Each of the five states submitted wholesale importation plans during the first Trump Administration. Only Florida has obtained full federal approval to date, however that state's implementation is still pending. Recent developments, such as tariffs on Canadian goods – including pharmaceuticals – proposed by the Trump Administration in the first quarter of 2025, could lessen the savings potential from wholesale importation.

Additionally, tensions between Canada and the United States recently have been escalating. Prior to the current conflict over tariffs, Florida several years ago enacted a wholesale importation law which was strongly opposed by Canadian officials, who stated they would not allow the export of pharmaceuticals licensed in Canada for the Canadian market. They pointed out that the population of the state of Florida (~23.5M) is more than half the population of the entire country of Canada (~41.5M) and exporting to the U.S. would strain Canada's domestic pharmaceutical supply. Worsening relations between the United States and Canada make the prospect of wholesale importation even more remote. Despite growing improbability of success, as many as nine states had wholesale importation bills in their 2025 legislative sessions. [49]

Personal Importation from Canada or Mexico

While personal importation – enacted by patients themselves through travel or mail order – is not currently legal in the United States, the U.S. Food and Drug Administration (FDA) does not generally enforce the prohibition on importation if the imported product is for personal use only and limited to a 90-day supply. In February 2025, Senator Tammy Baldwin (D-WI) introduced a bill (SB641) to fully legalize personal importation. Several New England senators joined her – Peter Welch (D-VT), Jeanne Shaheen (D-NH), and Angus King (I-ME).

The Utah State Employees Benefit Program facilitates and encourages personal importation of prescription drugs from Canada or Mexico. Utah actively encourages its state government employees to search for the least expensive source for medical products, services, and pharmaceuticals. To that end, the employee benefit program facilitates and encourages medical tourism for pharmacy products. Enrollees who use

[48] Colorado, Florida, Maine, New Mexico, and Vermont.

[49] Connecticut, Illinois, Mississippi, New York, Rhode Island, Tennessee, Texas, West Virginia, and Wisconsin.

one or more of the drugs on the program's specific list of drugs (determined by the employee plan) can travel to Tijuana or Vancouver to fill a 90-day prescription. The state covers the cost of air and ground transportation and one hotel night if needed. Additionally, the employee pays a reduced cost-share amount and receives an incentive payment up to $750 for each prescription/trip.[14]

Along with the State of Utah, some private employers and local government employers have set up personal importation mail-order pharmacy programs using vendors for their benefits plan enrollees. Some employers are also supporting medical tourism for certain medical procedures and providing employee incentives to use these services, which are organized by companies that manage and coordinate scheduling and travel for the employees/patients.

State Offices for Pharmaceutical Procurement

Procurement strategies can be used to address pharmacy spending within state government. Such strategies can be scaled up or down and, thus, are suitable for both large and small states. For example, Massachusetts and California have different versions of procurement that centralize some amount of pharmaceutical contracting and purchasing for a variety of state agencies, facilities, departments, or programs.

California

In California, expansion of coordinated pharmaceutical procurement was jump-started by the Governor's 2019 Executive Order that built upon existing purchasing collaboration among some agencies. The Department of General Services manages a statewide formulary on behalf of many state, county and local facilities, departments, agencies, colleges, universities, and programs. The enterprise is known as the Statewide Pharmaceutical Program.[50]

Participants agree to utilize the drugs on the statewide formulary. General Services negotiates pricing with manufacturers, wholesalers, suppliers, PBMs, and group purchasing organizations such as MMCAPInfuse (discussed later). Some of the price agreements result in sole-sourced drugs where participating entities must use the sole-sourced product rather than a competitor or another product in the drug class.

The selection of products on the statewide formulary is informed by a consensus among members of the California Pharmaceutical Collaborative; its members are representative of the agencies that are part of the Statewide Formulary Program. The Collaborative also works on a wide range of pharmacy management issues and related services.

Massachusetts

Massachusetts created its Office for Pharmacy Services in 1992. The Office procures for the Commonwealth departments of public health, corrections, developmental services, mental health, veterans' homes, and sheriffs' facilities. From the Commonwealth Office website:

[50] Statewide pharmaceutical program. California Department of General Services. Link (accessed December 2025): https://www.dgs.ca.gov/PD/About/Page-Content/PD-Branch-Intro-Accordion-List/Acquisitions/Statewide-Pharmaceutical-Program

> State Office for Pharmacy Services' [mission] is to provide state-of-the-art pharmaceutical care through clinically appropriate and operationally efficient drug-therapy management in a safe and effective manner. SOPS provides the Commonwealth of Massachusetts an integrated system benefiting several separate and distinct agencies within Executive Office of Health and Human Services (EOHHS) and Executive Office of Public Safety and Security (EOPSS). By standardizing policies and procedures, medication distribution systems and personnel, the SOPS program has been able to raise the quality of pharmacy services and deliver economic benefits to the agencies.

New Mexico

New Mexico once pursued a similar effort through the Interagency Pharmaceutical Procurement Council (IPPC), created by the legislature specifically for the purpose of multi-agency contracting for prescription drugs. The IPPC included direct purchasers (such as correctional facilities and public health agencies) and employee benefit plans that reimbursed purchasers when a drug was dispensed to an enrollee. The intent of the IPCC was to sort through the myriad issues among pharmacy benefits management, formulary design and payment among the various employee benefits programs, as well as issues and differences between payers and state facilities purchasers, such as soldiers' homes, juvenile residential facilities, and state hospitals, among others.

Based on the IPPC website, the initiative faded out in the fall of 2022 after three years in existence, in part because different programs and agencies were entrenched in their approaches to purchasing or formularies in contracts with established vendors. Different state entities had different pharmaceutical product needs and different procurement sources. Additionally, there was no full-time staff to manage the work of the IPPC and, unlike the California and Massachusetts initiatives, there was little willingness for collaboration among the different parties in New Mexico.

Legislation Considered in Other States

In addition to the efforts discussed above, a handful of additional states have considered legislation for the creation of a similar organization but none of the proposed bills were enacted:

- **Connecticut.** Proposed legislation to create a multi-agency purchasing entity organized through the state university healthcare system. The legislation further suggested that the university explore interstate compacts for multi-state purchasing.
- **Oregon.** Proposed legislation to create the Office of Pharmaceutical Purchasing within the Oregon Department of Administrative Services, which would have supported multi-agency and multi-state collaborative purchasing of pharmaceuticals.
- **Virginia.** Proposed legislation to create a statewide Office of Pharmaceutical Services within the Department of General Services.
- **Wisconsin**. Proposed legislation to study consolidated drug purchasing.

Existing Multi-State Arrangements

Multi-state and even intrastate, multi-agency efforts to address prescription drug costs are challenging for multiple reasons.

- **Coordination and cooperation**. Coordination across agencies or states is difficult – and prescription-drug cost and supply management done in coalition is complex and fraught.
- **Legal barriers**. Seemingly "obvious" answers to drug cost management may violate not-so-obvious federal statutes. Collaborative efforts may become bogged down by or buried under conflicting procurement processes of different agencies or states. These unaligned processes are governed by durable state law and/or regulations that cannot be ignored and are difficult to change in a timely fashion.
- **Conflicting goals**. Different agencies and different states may have subtle but different outcomes in mind for collaboration which may not easily be reconciled.
- **Resistance to change**. Simply put, it can be much easier and therefore more likely to get to "NO, we can't…" than "YES, we can."

Some multi-state efforts have succeeded and continue. These are outlined below.

Medicaid Pharmacy Supplemental Rebate Groups

There are three separate multi-state Medicaid supplemental rebate pools that have existed for many years. States can come and go between and among the different groups that negotiate rebates from manufacturers; the supplemental rebates are in addition to the federal rebate requirements and amounts. The only state that has not participated is New Mexico. These groups are common knowledge among state Medicaid programs.

MMCAP Infuse[51]

MMCAP Infuse is operated by the State of Minnesota and is open to any state or local government entity. It is a group purchasing organization (GPO) for an array of pharmaceutical and healthcare products and services. The organization has existed since the 1980s and is generally well known among state entities that procure pharmaceuticals and healthcare products.

New England States Consortium Systems Organization (NESCSO)

NESCSO was established in 1998 and includes Vermont. Regarding pharmacy issues, the organization is particularly focused on the Medicaid pharmacy program. The group is a collaborative-learning organization for best practices and keeping abreast of important and timely issues such as implementation of Medicare MFPs for prescription drugs.

[51] Minnesota Multistate Contracting Alliance for Pharmacy-INFUSE

Appendix C. Act 134 of 2024

Act 134 (S.98) directs the Green Mountain Care Board (GMCB), in consultation with others, to explore and create a framework and methodology for implementing a program to regulate prescription drug costs in Vermont. The GMCB's preliminary plan was submitted to the Vermont General Assembly on January 15, 2025, with the final plan due on or before January 15, 2026. The act created two new positions at the GMCB to lead the exploration, development, and implementation of the prescription drug pricing program and adds the GMCB's prescription drug cost regulation initiatives as allowable uses of monies in the Evidence-Based Education and Advertising Fund.[52] The act appropriates $245,000 from that Fund for the new positions and an additional $250,000 from the Fund for contracts with experts on prescription drug-related issues to help the GMCB with its work.[53]

In its work under this statute, the Board shall consider options for and likely impacts of regulating the cost of prescription drugs, including:

(1) the experiences of states that have developed prescription drug affordability boards;
(2) the Centers for Medicare and Medicaid Services' development and operation of the Medicare Drug Price Negotiation Program;
(3) other promising federal and state strategies for lowering prescription drug costs;
(4) the Board's existing authority to set rates, adopt rules, and establish technical advisory groups;
(5) the likely return on investment of the most promising program options;
(6) the potential impacts on Vermonters' access to medications; and
(7) the impact of implementing a program to regulate the costs of prescription drugs on other State agencies and on the private sector.[54]

[52] 33 V.S.A. § 2004a Link: https://legislature.vermont.gov/statutes/section/33/019/02004a

[53] Summary of Act 134 Link: https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT134/ACT134%20Act%20Summary.pdf

[54] Act 134 as enacted Link: https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT134/ACT134%20As%20Enacted.pdf