1 TO THE HOUSE OF REPRESENTATIVES:

2 The Committee on Health Care to which was referred House Bill No. 233
3 entitled "An act relating to pharmacy benefit management and Medicaid
4 wholesale drug distribution" respectfully reports that it has considered the
5 same and recommends that the bill be amended by striking out all after the
6 enacting clause and inserting in lieu thereof the following:

7 Sec. 1. 18 V.S.A. chapter 77 is added to read:

8 CHAPTER 77. PHARMACY BENEFIT MANAGERS

9 Subchapter 1. General Provisions

10 § 3601. PURPOSE

11 The purpose of this chapter is to establish standards and criteria for the
12 licensure and regulation of pharmacy benefit managers providing claims
13 processing services or other prescription drug or device services for health
14 benefit plans by:

15 (1) promoting, preserving, and protecting the public health, safety, and
16 welfare through effective regulation and licensure of pharmacy benefit
17 managers;

18 (2) promoting the solvency of the commercial health insurance industry,
19 the regulation of which is reserved to the states by the McCarran-Ferguson
20 Act, 15 U.S.C. §§ 1011–1015, as well as providing for consumer savings and
21 for fairness in prescription drug benefits;

1 (3) providing for the powers and duties of the Commissioner of
2 Financial Regulation; and
3 (4) prescribing penalties and fines for violations of this chapter.
4 § 3602. DEFINITIONS
5 As used in this chapter:
6 (1) "Claims processing services" means the administrative services
7 performed in connection with the processing and adjudicating of claims
8 relating to pharmacist services that include receiving payments for pharmacist
9 services or making payments to pharmacists or pharmacies for pharmacy
10 services, or both.
11 (2) "Commissioner" means the Commissioner of Financial Regulation.
12 (3) "Covered person" means a member, policyholder, subscriber,
13 enrollee, beneficiary, dependent, or other individual participating in a health
14 benefit plan.
15 (4) "Health benefit plan" means a policy, contract, certificate, or
16 agreement entered into, offered, or issued by a health insurer to provide,
17 deliver, arrange for, pay for, or reimburse any of the costs of physical, mental,
18 or behavioral health care services.
19 (5) "Health insurer" has the same meaning as in section 9402 of this title
20 and includes:

1 (A) health insurance companies, nonprofit hospital and medical
2 service corporations, and health maintenance organizations;
3 (B) employers, labor unions, and other group of persons organized in
4 Vermont that provide a health benefit plan to beneficiaries who are employed
5 or reside in Vermont; and
6 (C) the State of Vermont and any agent or instrumentality of the State
7 that offers, administers, or provides financial support to State government.
8 (6) "Maximum allowable cost" means the per unit drug product
9 reimbursement amount, excluding dispensing fees, for a group of equivalent
10 multisource prescription drugs.
11 (7) "Other prescription drug or device services" means services other
12 than claims processing services provided directly or indirectly, whether in
13 connection with or separate from claims processing services, and may include:
14 (A) negotiating rebates, price concessions, discounts, or other
15 financial incentives and arrangements with drug companies;
16 (B) disbursing or distributing rebates or price concessions, or both;
17 (C) managing or participating in incentive programs or arrangements
18 for pharmacist services;
19 (D) negotiating or entering into contractual arrangements with
20 pharmacists or pharmacies, or both;
21 (E) developing and maintaining formularies;

1 (F) designing prescription benefit programs; and
2 (G) advertising or promoting services.
3 (8) "Pharmacist" means an individual licensed as a pharmacist pursuant
4 to 26 V.S.A. chapter 36.
5 (9) "Pharmacist services" means products, goods, and services, or a
6 combination of these, provided as part of the practice of pharmacy.
7 (10) "Pharmacy" means a place licensed by the Vermont Board of
8 Pharmacy at which drugs, chemicals, medicines, prescriptions, and poisons are
9 compounded, dispensed, or sold at retail.
10 (11) "Pharmacy benefit management" means an arrangement for the
11 procurement of prescription drugs at a negotiated rate for dispensation within
12 this State to beneficiaries, the administration or management of prescription
13 drug benefits provided by a health benefit plan for the benefit of beneficiaries,
14 or any of the following services provided with regard to the administration of
15 pharmacy benefits:
16 (A) mail service pharmacy;
17 (B) claims processing, retail network management, and payment of
18 claims to pharmacies for prescription drugs dispensed to beneficiaries;
19 (C) clinical formulary development and management services;
20 (D) rebate contracting and administration;

1 (E) certain patient compliance, therapeutic intervention, and generic
2 substitution programs; and
3 (F) disease or chronic care management programs.
4 (12)(A) “Pharmacy benefit manager” means an individual, corporation,
5 or other entity, including a wholly or partially owned or controlled subsidiary
6 of a pharmacy benefit manager, that provides pharmacy benefit management
7 services for health benefit plans.
8 (B) The term “pharmacy benefit manager” does not include:
9 (i) a health care facility licensed in this State;
10 (ii) a health care professional licensed in this State;
11 (iii) a consultant who only provides advice as to the selection or
12 performance of a pharmacy benefit manager;
13 (iv) a health insurer to the extent that it performs any claims
14 processing and other prescription drug or device services exclusively for its
15 enrollees; or
16 (v) an entity that provides pharmacy benefit management services
17 for Vermont Medicaid.
18 (13) “Pharmacy benefit manager affiliate” means a pharmacy or
19 pharmacist that, directly or indirectly, through one or more intermediaries, is
20 owned or controlled by, or is under common ownership or control with, a
21 pharmacy benefit manager.

§ 3603. RULEMAKING

The Commissioner of Financial Regulation shall adopt rules in accordance with 3 V.S.A. chapter 25 to carry out the provisions of this chapter. The rules shall include, as appropriate, requirements that health insurers maintain the confidentiality of proprietary information and that pharmacy benefit managers file their advertising and solicitation materials with the Commissioner for approval prior to sending any such materials to patients or consumers.

§ 3604. REPORTING

Annually on or before January 15, the Department of Financial Regulation shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding pharmacy benefit managers' compliance with the provisions of this chapter.

Subchapter 2. Pharmacy Benefit Manager Licensure and Regulation

§ 3611. LICENSURE

(a) A person shall not establish or operate as a pharmacy benefit manager for health benefit plans in this State without first obtaining a license from the Commissioner of Financial Regulation.

(b) A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the Commissioner and shall include with the application a nonrefundable application fee of ~~$100.00~~ **$2,500.00** and a licensure fee of ~~$500.00~~ **$1,000.00**.

(c) The Commissioner may refuse to issue or renew a pharmacy benefit manager license if the Commissioner determines that the applicant or any individual responsible for the conduct of the applicant's affairs is not competent, trustworthy, financially responsible, or of good personal and business reputation, or has been found to have violated the insurance laws of this State or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

(d) Unless surrendered, suspended, or revoked by the Commissioner, a license issued under this section shall remain valid, provided the pharmacy benefit manager does all of the following:

(1) Continues to do business in this State.

(2) Complies with the provisions of this chapter and any applicable rules.

(3) Submits a renewal application in the form and manner prescribed by the Commissioner and pays the annual license renewal fee of ~~$500.00~~ **$1,000.00**. The renewal application and renewal fee shall be due to the Commissioner on or before 90 days prior to the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

(e) The Commissioner shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish the licensing application, financial, and reporting requirements for pharmacy benefit managers in accordance with this section.

1 § 3612. PROHIBITED PRACTICES

2 (a) A participation contract between a pharmacy benefit manager and a
3 pharmacist shall not prohibit, restrict, or penalize a pharmacy or pharmacist in
4 any way from disclosing to any covered person any health care information
5 that the pharmacy or pharmacist deems appropriate, including:

6 (1) the nature of treatment, risks, or alternatives to treatment;

7 (2) the availability of alternate therapies, consultations, or tests;

8 (3) the decision of utilization reviewers or similar persons to authorize
9 or deny services;

10 (4) the process that is used to authorize or deny health care services; or

11 (5) information on financ**ial** incentives and structures used by the health
12 insurer.

13 (b) A pharmacy benefit manager shall not prohibit a pharmacy or
14 pharmacist from:

15 (1) discussing information regarding the total cost for pharmacist
16 services for a prescription drug;

17 (2) providing information to a covered person regarding the covered
18 person’s cost-sharing amount for a prescription drug;

19 (3) disclosing to a covered person the cash price for a prescription drug;
20 or

1 (4) selling a more affordable alternative to the covered person if a more
2 affordable alternative is available.
3 (c) A pharmacy benefit manager contract with a participating pharmacist or
4 pharmacy shall not prohibit, restrict, or limit disclosure of information to the
5 Commissioner, law enforcement, or State and federal government officials,
6 provided that:
7 (1) the recipient of the information represents that the recipient has the
8 authority, to the extent provided by State or federal law, to maintain
9 proprietary information as confidential; and
10 (2) prior to disclosure of information designated as confidential, the
11 pharmacist or pharmacy:
12 (A) marks as confidential any document in which the information
13 appears; and
14 (B) requests confidential treatment for any oral communication of the
15 information.
16 (d) A pharmacy benefit manager shall not terminate a contract with or
17 penalize a pharmacist or pharmacy due to the pharmacist or pharmacy:
18 (1) disclosing information about pharmacy benefit manager practices,
19 except for information determined to be a trade secret under State law or by the
20 Commissioner, when disclosed in a manner other than in accordance with
21 subsection (c) of this section; or

1 (2) sharing any portion of the pharmacy benefit manager contract with
2 the Commissioner pursuant to a complaint or query regarding the contract's
3 compliance with the provisions of this chapter.
4 (e)(1) A pharmacy benefit manager shall not require a covered person
5 purchasing a covered prescription drug to pay an amount greater than the lesser
6 of:
7 (A) the cost-sharing amount under the terms of the health benefit
8 plan, as determined in accordance with subdivision (2) of this subsection (e);
9 (B) the maximum allowable cost for the drug; ~~or~~
10 (C) the amount the covered person would pay for the drug, after
11 application of any known discounts, if the covered person were paying the cash
12 price**; or**
13 **(D) the current National Average Drug Acquisition Cost, plus a**
14 **reasonable professional dispensing fee**.
15 ~~(2) As used in subdivision (1)(A) of this subsection (e), the "cost-~~
16 ~~sharing amount under the terms of the health benefit plan" shall be calculated~~
17 ~~at the point of sale based on a price that has been reduced by an amount equal~~
18 ~~to at least 100 percent of all rebates received, or to be received, in connection~~
19 ~~with the dispensing or administration of the drug. The pharmacy benefit~~
20 ~~manager shall pass on any remaining rebate amount in excess of the covered~~
21 ~~person's cost-sharing amount to the health benefit plan to reduce premiums.~~

1 **(2)(A) At least annually, a health benefit plan shall determine for**
2 **each covered person the total amount of all rebates the plan or its**
3 **pharmacy benefit manager received in connection with the dispensing or**
4 **administration of a drug to the person and shall pass along that amount to**
5 **the covered person whose use of the drug or drugs generated the rebates.**
6 **If the amount of any rebate attributable to a covered person exceeds the**
7 **covered person's net out-of-pocket cost for the drug, the amount to be**
8 **passed through to the covered person shall equal the person's net out-of-**
9 **pocket cost for the drug and the plan shall retain any remaining rebate to**
10 **reduce premiums.**
11 **(B) As used in this subdivision (2), a covered person's net out-of-**
12 **pocket cost for a drug is the amount paid by or on behalf of the covered**
13 **person less any amount of drug manufacturer co-payment assistance**
14 **requested by the covered person that the plan applied to the person's**
15 **deductible and out-of-pocket maximum in accordance with subdivision (3)**
16 **of this subsection (e).**
17 (3)**(A)** A pharmacy benefit manager shall attribute any amount paid by
18 or on behalf of a covered person under subdivision (1) of this subsection (e),
19 including any third-party payment, financial assistance, discount, coupon, or
20 any other reduction in out-of-pocket expenses made by or on behalf of a
21 covered person for prescription drugs, toward**:**

1 **(i) the out-of-pocket limits for prescription drug costs under 8**
2 **V.S.A. § 4089i;**
3 **(ii)** ~~any~~ **the covered person's** deductible**, if any;** and~~,~~
4 **(iii)** to the extent **not in**consistent with Sec. 2707 of the Public
5 Health Service Act, 42 U.S.C. § 300gg-6, the annual out-of-pocket maximums
6 ~~under~~ **applicable to** the covered person's health benefit plan.
7 **(B) The provisions of subdivision (A) of this subdivision (3) shall**
8 **apply to a high-deductible health plan only to the extent that it would not**
9 **disqualify the plan from eligibility for a health savings account pursuant**
10 **to 26 U.S.C. § 223.**
11 (f) A pharmacy benefit manager shall not conduct or participate in spread
12 pricing in this State.
13 § 3613. ENFORCEMENT; RIGHT OF ACTION
14 (a) The Commissioner of Financial Regulation shall enforce compliance
15 with the provisions of this chapter.
16 (b)(1) The Commissioner may examine or audit the books and records of a
17 pharmacy benefit manager providing claims processing services or other
18 prescription drug or device services for a health benefit plan to determine
19 compliance with this chapter.
20 (2) Information or data acquired in the course of an examination or audit
21 under subdivision (1) of this subsection shall be considered proprietary and

1 confidential, shall be exempt from public inspection and copying under the
2 Public Records Act, shall not be subject to subpoena, and shall not be subject
3 to discovery or admissible in evidence in any private civil action.
4 (3) The Office of the Health Care Advocate shall have the right to
5 receive or review copies of all materials provided to or reviewed by the
6 Commissioner under this chapter in order to protect and promote patients' and
7 consumers' interests in accordance with the Office's duties under chapter 229
8 of this title. The Office of the Health Care Advocate shall not further disclose
9 any confidential or proprietary information provided to this Office pursuant to
10 this subdivision.
11 (c) The Commissioner may use any document or information provided
12 pursuant to subsection 3612(c) or (d) of this chapter in the performance of the
13 Commissioner's duties to determine compliance with this chapter.
14 (d) The Commissioner may impose a**n administrative** penalty on a
15 pharmacy benefit manager or the health insurer with which it is contracted, or
16 both, for a violation of this chapter **in accordance with 8 V.S.A. § 3661**. ~~The~~
17 ~~penalty shall be not less than $25,000.00 nor more than $50,000.00 for each~~
18 ~~violation of this chapter~~.
19 (e) A pharmacy, pharmacist, or other person injured by a pharmacy benefit
20 manager's violation of this chapter may bring an action in Superior Court
21 against the pharmacy benefit manager for injunctive relief, compensatory and

1 punitive damages, costs and reasonable attorney's fees, and other appropriate
2 relief.
3 § 3614. COMPLIANCE; CONSISTENCY WITH FEDERAL LAW
4 Nothing in this chapter is intended or should be construed to conflict with
5 applicable federal law.
6 § 3615. CHARGES FOR EXAMINATIONS, APPLICATIONS, REVIEWS,
7 AND INVESTIGATIONS
8 (a) The Department of Financial Regulation may charge its reasonable
9 expenses in administering the provisions of this chapter to pharmacy benefit
10 managers in the manner provided for in 8 V.S.A. § 18. These expenses shall
11 be allocated in proportion to the lives of Vermonters covered by each
12 pharmacy benefit manager as reported annually to the Commissioner in a
13 manner and form prescribed by the Commissioner.
14 (b) The Department of Financial Regulation shall not charge its expenses to
15 the pharmacy benefit manager contracting with the Department of Vermont
16 Health Access if the Department of Vermont Health Access notifies the
17 Department of Financial Regulation of the conditions contained in its contract
18 with a pharmacy benefit manager.
19 Subchapter 3. Pharmacy Benefit Manager Relations with Health Insurers
20 § 3621. INSURER AUDIT OF PHARMACY BENEFIT MANAGER
21 ACTIVITIES

1 In order to enable periodic verification of pricing arrangements in
2 administrative-services-only contracts, pharmacy benefit managers shall allow
3 access, in accordance with rules adopted by the Commissioner, by the health
4 insurer who is a party to the administrative-services-only contract to financial
5 and contractual information necessary to conduct a complete and independent
6 audit designed to verify the following:
7 (1) full pass through of negotiated drug prices and fees associated with
8 all drugs dispensed to beneficiaries of the health benefit plan in both retail and
9 mail order settings or resulting from any of the pharmacy benefit management
10 functions defined in the contract;
11 (2) full pass through of all financial remuneration associated with all
12 drugs dispensed to beneficiaries of the health benefit plan in both retail and
13 mail order settings or resulting from any of the pharmacy benefit management
14 functions defined in the contract; and
15 (3) any other verifications relating to the pricing arrangements and
16 activities of the pharmacy benefit manager required by the contract if required
17 by the Commissioner.
18 § 3622. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES
19 WITH RESPECT TO HEALTH INSURERS
20 (a) A pharmacy benefit manager that provides pharmacy benefit
21 management for a health benefit plan has a fiduciary duty to its health insurer

1 client that includes a duty to be fair and truthful toward the health insurer; to
2 act in the health insurer's best interests; and to perform its duties with care,
3 skill, prudence, and diligence. In the case of a health benefit plan offered by a
4 health insurer as defined by subdivision 3602(5)(A) of this title, the health
5 insurer shall remain responsible for administering the health benefit plan in
6 accordance with the health insurance policy or subscriber contract or plan and
7 in compliance with all applicable provisions of Title 8 and this title.
8 (b) A pharmacy benefit manager shall provide notice to the health insurer
9 that the terms contained in subsection (c) of this section may be included in the
10 contract between the pharmacy benefit manager and the health insurer.
11 (c) A pharmacy benefit manager that provides pharmacy benefit
12 management for a health plan shall do all of the following:
13 (1) Provide all financial and utilization information requested by a
14 health insurer relating to the provision of benefits to beneficiaries through that
15 health insurer's health benefit plan and all financial and utilization information
16 relating to services to that health insurer. A pharmacy benefit manager
17 providing information under this subsection may designate that material as
18 confidential. Information designated as confidential by a pharmacy benefit
19 manager and provided to a health insurer under this subsection shall not be
20 disclosed by the health insurer to any person without the consent of the

1 pharmacy benefit manager, except that disclosure may be made by the health
2 insurer:
3 (A) in a court filing under the consumer protection provisions of
4 9 V.S.A. chapter 63, provided that the information shall be filed under seal and
5 that prior to the information being unsealed, the court shall give notice and an
6 opportunity to be heard to the pharmacy benefit manager on why the
7 information should remain confidential;
8 (B) to State and federal government officials;
9 (C) when authorized by 9 V.S.A. chapter 63;
10 (D) when ordered by a court for good cause shown; or
11 (E) when ordered by the Commissioner as to a health insurer as
12 defined in subdivision 3602(5)(A) of this chapter pursuant to the provisions of
13 Title 8 and this title.
14 (2) Notify a health insurer in writing of any proposed or ongoing
15 activity, policy, or practice of the pharmacy benefit manager that presents,
16 directly or indirectly, any conflict of interest with the requirements of this
17 section.
18 (3) With regard to the dispensation of a substitute prescription drug for a
19 prescribed drug to a beneficiary in which the substitute drug costs more than
20 the prescribed drug and the pharmacy benefit manager receives a benefit or
21 payment directly or indirectly, disclose to the health insurer the cost of both

1 drugs and the benefit or payment directly or indirectly accruing to the
2 pharmacy benefit manager as a result of the substitution.
3 (4) If the pharmacy benefit manager derives any payment or benefit for
4 the dispensation of prescription drugs within the State based on volume of
5 sales for certain prescription drugs or classes or brands of drugs within the
6 State, pass that payment or benefit on in full to the health insurer.
7 (5) Disclose to the health insurer all financial terms and arrangements
8 for remuneration of any kind that apply between the pharmacy benefit manager
9 and any prescription drug manufacturer that relate to benefits provided to
10 beneficiaries under or services to the health insurer's health benefit plan,
11 including formulary management and drug-switch programs, educational
12 support, claims processing, and pharmacy network fees charged from retail
13 pharmacies and data sales fees. A pharmacy benefit manager providing
14 information under this subsection may designate that material as confidential.
15 Information designated as confidential by a pharmacy benefit manager and
16 provided to a health insurer under this subsection shall not be disclosed by the
17 health insurer to any person without the consent of the pharmacy benefit
18 manager, except that disclosure may be made by the health insurer:
19 (A) in a court filing under the consumer protection provisions of
20 9 V.S.A. chapter 63, provided that the information shall be filed under seal and
21 that prior to the information being unsealed, the court shall give notice and an

1 opportunity to be heard to the pharmacy benefit manager on why the
2 information should remain confidential;
3 (B) when authorized by 9 V.S.A. chapter 63;
4 (C) when ordered by a court for good cause shown; or
5 (D) when ordered by the Commissioner as to a health insurer as
6 defined in subdivision 3602(5)(A) of this title pursuant to the provisions of
7 Title 8 and this title.
8 (d) A pharmacy benefit manager contract with a health insurer shall not
9 contain any provision purporting to reserve discretion to the pharmacy benefit
10 manager to move a drug to a higher tier or remove a drug from its drug
11 formulary any more frequently than two times per year.
12 (e) ~~At least annually, a pharmacy benefit manager that provides pharmacy~~
13 ~~benefit management for a health benefit plan shall disclose to the health~~
14 ~~insurer, the Department of Financial Regulation, the Green Mountain Care~~
15 ~~Board, and the Office of the Health Care Advocate the aggregate amount the~~
16 ~~pharmacy benefit manager retained on all claims charged to the health insurer~~
17 ~~for prescriptions filled during the preceding calendar year in excess of the~~
18 ~~amount the pharmacy benefit manager reimbursed pharmacies.~~
19 ~~(f)~~ Compliance with the requirements of this section is required for
20 pharmacy benefit managers entering into contracts with a health insurer in this
21 State for pharmacy benefit management in this State.

1 Subchapter 4. Pharmacy Benefit Manager Relations with Pharmacies
2 § 3631. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES
3 WITH RESPECT TO PHARMACIES
4 (a) Within 14 calendar days following receipt of a pharmacy claim, a
5 pharmacy benefit manager or other entity paying pharmacy claims shall do one
6 of the following:
7 (1) Pay or reimburse the claim.
8 (2) Notify the pharmacy in writing that the claim is contested or denied.
9 The notice shall include specific reasons supporting the contest or denial and a
10 description of any additional information required for the pharmacy benefit
11 manager or other payer to determine liability for the claim.
12 (b) In addition to the practices prohibited by section 3612 of this chapter, a
13 pharmacy benefit manager or other entity paying pharmacy claims shall not
14 require a pharmacy to pass through any portion of the insured's co-payment, or
15 patient responsibility, to the pharmacy benefit manager or other payer.
16 (c) For each drug for which a pharmacy benefit manager establishes a
17 maximum allowable cost in order to determine the reimbursement rate, the
18 pharmacy benefit manager shall do all of the following:
19 (1) Make available, in a format that is readily accessible and
20 understandable by a pharmacist, the actual maximum allowable cost for each
21 drug and the source used to determine the maximum allowable cost, which

1 shall not be dependent upon individual beneficiary identification or benefit
2 stage.
3 (2) Update the maximum allowable cost at least once every seven
4 calendar days. In order to be subject to maximum allowable cost, a drug must
5 be widely available for purchase by all pharmacies in the State, without
6 limitations, from national or regional wholesalers and must not be obsolete or
7 temporarily unavailable.
8 (3) Establish or maintain a reasonable administrative appeals process to
9 allow a dispensing pharmacy provider to contest a listed maximum allowable
10 cost.
11 (4)(A) Respond in writing to any appealing pharmacy provider within
12 10 calendar days after receipt of an appeal, provided that, except as provided in
13 subdivision (B) of this subdivision (4), a dispensing pharmacy provider shall
14 file any appeal within 10 calendar days from the date its claim for
15 reimbursement is adjudicated.
16 (B) A pharmacy benefit manager shall allow a dispensing pharmacy
17 provider to appeal after the 10-calendar-day appeal period set forth in
18 subdivision (A) of this subdivision (4) if the prescription claim is subject to an
19 audit initiated by the pharmacy benefit manager or its auditing agent.
20 (5) For a denied appeal, provide the reason for the denial and identify
21 the national drug code and a Vermont-licensed wholesaler of an equivalent

drug product that may be purchased by contracted pharmacies at or below the maximum allowable cost.

(6) For an appeal in which the appealing pharmacy is successful:

(A) make the change in the maximum allowable cost within 30 business days after the redetermination; and

(B) allow the appealing pharmacy or pharmacist to reverse and rebill the claim in question.

~~(d) If a pharmacy benefit manager denies a pharmacy's or pharmacist's appeal in whole or in part without identifying the national drug code and a Vermont-licensed wholesaler of an equivalent drug product that may be purchased by contracted pharmacies at or below the maximum allowable cost, and the reimbursement amount is less than the pharmacy's actual acquisition cost plus a dispensing fee, the pharmacy or pharmacist may submit a claim to the health insurer for the balance and the health insurer shall reimburse the pharmacy or pharmacist that amount.~~

~~(e) A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services. The reimbursement amount shall be calculated on a per-unit basis based on the pharmacy's actual acquisition cost and shall include a professional dispensing fee that shall be not less than the professional~~

1 ~~dispensing fee established for the Vermont Medicaid program by the~~
2 ~~Department of Vermont Health Access in accordance with 42 C.F.R. Part 447.~~
3 (d) A pharmacy benefit manager shall not restrict, limit, or impose
4 requirements on a licensed pharmacy in excess of those set forth by the
5 Vermont Board of Pharmacy or by other State or federal law, nor shall it
6 withhold reimbursement for services on the basis of noncompliance with
7 participation requirements.
8 (e) A pharmacy benefit manager shall provide notice to all participating
9 pharmacies prior to changing its drug formulary.
10 (f)(1) A pharmacy benefit manager or other third party that reimburses a
11 340B covered entity for drugs that are subject to an agreement under 42 U.S.C.
12 § 256b through the 340B drug pricing program shall not reimburse the 340B
13 covered entity for pharmacy-dispensed drugs at a rate lower than that paid for
14 the same drug to pharmacies that are not 340B covered entities, and the
15 pharmacy benefit manager shall not assess any fee, charge-back, or other
16 adjustment on the 340B covered entity on the basis that the covered entity
17 participates in the 340B program as set forth in 42 U.S.C. § 256b.
18 (2) With respect to a patient who is eligible to receive drugs that are
19 subject to an agreement under 42 U.S.C. § 256b through the 340B drug pricing
20 program, a pharmacy benefit manager or other third party that makes payment
21 for the drugs shall not discriminate against a 340B covered entity in a manner

1 that prevents or interferes with the patient’s choice to receive the drugs from
2 the 340B covered entity.
3 **(3) As used in this section, “other third party” does not include**
4 **Vermont Medicaid.**
5 (g) A pharmacy benefit manager shall not:
6 (1) require a claim for a drug to include a modifier or supplemental
7 transmission, or both, to indicate that the drug is a 340B drug unless the claim
8 is for payment, directly or indirectly, by Medicaid; or
9 (2) restrict access to a pharmacy network or adjust reimbursement rates
10 based on a pharmacy’s participation in a 340B contract pharmacy arrangement.
11 Sec. 2. 8 V.S.A. § 4084 is amended to read:
12 § 4084. ADVERTISING PRACTICES
13 (a) No company doing business in this State, and no insurance agent or
14 broker, shall use in connection with the solicitation of health insurance or
15 pharmacy benefit management any advertising copy or advertising practice or
16 any plan of solicitation ~~which~~ that is materially misleading or deceptive. An
17 advertising copy or advertising practice or plan of solicitation shall be
18 considered to be materially misleading or deceptive if by implication or
19 otherwise it transmits information in such manner or of such substance that a
20 prospective applicant for health insurance may be misled ~~thereby to his or her~~
21 by it to the applicant’s material damage.

1 (b)(1) If the Commissioner finds that any such advertising copy or
2 advertising practice or plan of solicitation is materially misleading or deceptive
3 ~~he or she~~, the Commissioner shall order the company or the agent or broker
4 using such copy or practice or plan to cease and desist from such use.
5 (2) Before making any such finding and order, the Commissioner shall
6 give notice, not less than 10 days in advance, and a hearing to the company,
7 agent, or broker affected.
8 (3) If the Commissioner finds, after due notice and hearing, that any
9 authorized insurer, licensed pharmacy benefit manager, licensed insurance
10 agent, or licensed insurance broker has ~~wilfully~~ intentionally violated any such
11 order to cease and desist ~~he or she~~, the Commissioner may suspend or revoke
12 the license of such insurer, pharmacy benefit manager, agent, or broker.
13 Sec. 3. 8 V.S.A. § 4089j is amended to read:
14 § 4089j. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS
15 (a) As used in this section:
16 * * *
17 (6) "Direct solicitation" means direct contact, including telephone,
18 computer, e-mail, instant messaging, or in-person contact, by a pharmacy
19 provider or its agent to a beneficiary of a plan offered by a health insurer
20 without the beneficiary's consent for the purpose of marketing the pharmacy
21 provider's services.

1 * * *

2 (d)(1) A health insurer or pharmacy benefit manager shall permit a
3 participating network pharmacy to perform all pharmacy services within the
4 lawful scope of the profession of pharmacy as set forth in 26 V.S.A. chapter
5 36.

6 (2) A health insurer or pharmacy benefit manager shall not do any of the
7 following:

8 * * *

9 (F)**(i)** Exclude any amount paid by or on behalf of a covered ~~person~~
10 **individual**, including any third-party payment, financial assistance, discount,
11 coupon, or other reduction, when calculating a covered individual's
12 contribution ~~to~~ toward**:**

13 **(I) the out-of-pocket limits for prescription drug costs**
14 **under section 4089i of this title;**

15 **(II)** ~~any~~ **the covered individual's** deductible**, if any;** or~~,~~

16 **(III)** to the extent not inconsistent with Sec. 2707 of the Public
17 Health Service Act, 42 U.S.C. § 300gg-6, the **annual** out-of-pocket maximums
18 applicable to the covered ~~person's~~ **individual's** health benefit plan.

19 **(ii) The provisions of subdivision (i) of this subdivision (F)**
20 **shall apply to a high-deductible health plan only to the extent that it would**

1 **not disqualify the plan from eligibility for a health savings account**
2 **pursuant to 26 U.S.C. § 223.**
3 * * *
4 (5) A health insurer or pharmacy benefit manager shall adhere to the
5 definitions of prescription drugs and the requirements and guidance regarding
6 the pharmacy profession established by State and federal law and the Vermont
7 Board of Pharmacy and shall not establish classifications of or distinctions
8 between prescription drugs, impose penalties on prescription drug claims,
9 attempt to dictate the behavior of pharmacies or pharmacists, or place
10 restrictions on pharmacies or pharmacists that are more restrictive than or
11 inconsistent with State or federal law or with rules adopted or guidance
12 provided by the Board of Pharmacy.
13 (6) A pharmacy benefit manager or licensed pharmacy shall not make a
14 direct solicitation to the beneficiary of a plan offered by a health insurer unless
15 one or more of the following applies:
16 (A) the beneficiary has given written permission to the supplier or the
17 ordering health care professional to contact the beneficiary regarding the
18 furnishing of a prescription item that is to be rented or purchased;
19 (B) the supplier has furnished a prescription item to the beneficiary
20 and is contacting the beneficiary to coordinate delivery of the item; or

1 (C) if the contact relates to the furnishing of a prescription item other
2 than a prescription item already furnished to the beneficiary, the supplier has
3 furnished at least one prescription item to the beneficiary within the 15-month
4 period preceding the date on which the supplier attempts to make the contact.
5 (8) The provisions of this subsection shall not apply to Medicaid.
6 (e) A health insurer or pharmacy benefit manager shall not alter a patient's
7 prescription drug order or the pharmacy chosen by the patient without the
8 patient's consent**; provided, however, that nothing in this subsection shall**
9 **be construed to affect the duty of a pharmacist to substitute a lower-cost**
10 **drug or biological product in accordance with the provisions of 18 V.S.A.**
11 **§ 4605**.
12 Sec. 4. ~~33 V.S.A. § 2011 is added to read:~~
13 ~~§ 2011.~~ WHOLESALE DRUG DISTRIBUTOR ~~CONTRACT~~ **PROGRAM;**
14 **WORKING GROUP; REPORT**
15 (a) As used in this section~~:~~**,**
16 ~~(1) "Dead net cost" means the wholesale acquisition cost of a~~
17 ~~prescription drug, less any applicable discounts and all vendor rebates, fees,~~
18 ~~and incentives, including inventory management agreement fees, fee-for-~~
19 ~~service agreements, volume incentives, rebates, and reporting fees.~~
20 ~~(2)~~ "wholesale drug distributor" has the same meaning as "wholesale
21 distributor" in 26 V.S.A. § 2022.

(b) The Agency of Human Services shall ~~establish a competitive bidding process for a~~ **convene a working group to consider how to implement a program through which one or more** ~~wholesale drug distributor, or for several~~ wholesale drug distributors ~~through a group purchasing organization, through which the selected wholesaler or group purchasing organization shall~~ **would** be the sole source to distribute prescription drugs to the community and outpatient pharmacies with which the wholesaler ~~or group purchasing organization enters~~ **or wholesalers would enter** into contracts for prescription drugs dispensed to beneficiaries of Medicaid and **of** other State health assistance programs for which the Department of Vermont Health Access pays pharmaceutical claims. The ~~Agency of Human Services shall convene a group comprising~~ **working group shall comprise** one representative each from the Green Mountain Care Board, the Department of Vermont Health Access, the Vermont Board of Pharmacy, the Vermont Association of Chain Drug Stores, ~~and~~ the Vermont Community Pharmacy Network**, the Office of the Health Care Advocate, Vermont-NEA, and the Vermont State Employees Association** ~~to conduct the competitive bidding process and to select the wholesale drug distributor or group purchasing organization that the group determines:~~

(c) **The working group shall develop a plan for implementing a wholesale drug distribution program that:**

1 (1) will offer the greatest cost savings to the Department of Vermont
2 Health Access;
3 (2) will provide complete transparency; and
4 (3) ~~demonstrates a willingness~~ **provides opportunities** to facilitate
5 additional savings throughout the State by expanding ~~the program~~ to **include**
6 additional public and private purchasers.
7 **(d) On or before January 15, 2025, the Agency of Human Services**
8 **shall provide the working group's plan for wholesale drug distribution to**
9 **the House Committee on Health Care and the Senate Committee on**
10 **Health and Welfare.**
11 ~~The wholesale drug distributor or group purchasing organization selected~~
12 ~~pursuant to subsection (b) of this section shall:~~
13 ~~(1) establish contracts with all Medicaid-participating community and~~
14 ~~outpatient pharmacies operating in this State;~~
15 ~~(2) maintain compliance with all applicable federal and State statutes,~~
16 ~~rules, and regulations relating to the operation of a wholesale drug distributor~~
17 ~~or group purchasing organization;~~
18 ~~(3) segregate the commercial portion of its pharmacy business from the~~
19 ~~Vermont Medicaid portion;~~
20 ~~(4) match the Department of Vermont Health Access's reports of claims~~
21 ~~paid per pharmacy with the pharmacies' invoices;~~

~~(5) invoice the Department of Vermont Health Access in an amount equal to the aggregate sum of the wholesaler's or group purchasing organization's dead net costs for all claims dispensed during a given period across all participating pharmacies;~~

~~(6) collaborate with the Department of Vermont Health Access to maximize the amount of direct manufacturer rebates and minimize the costs of the Medicaid formulary; and~~

~~(7) create a financial mechanism through which pharmacies shall be relieved of drug unit costs dispensed to Vermont Medicaid during the relevant period identified pursuant to subdivision (5) of this subsection.~~

~~(d) Only those community and outpatient pharmacies that agree to purchase their entire Vermont Medicaid inventory from the wholesaler or group purchasing organization selected pursuant to this section shall be eligible to establish or maintain enrollment as Medicaid-participating pharmacy providers.~~

~~(e) The Department of Vermont Health Access shall limit reimbursements to participating pharmacies to an amount equal to the established dispensing fee for prescription claims dispensed; provided, however, that this provision shall not be construed to prohibit the Department from reimbursing a participating pharmacy for recognized ancillary services provided in connection with these claims.~~

1 Sec. 5. REPEALS

2 The following are repealed on July 1, 202**4**:

3 (1) 18 V.S.A. § 9421 (pharmacy benefit management; registration;

4 insurer audit of pharmacy benefit manager activities); and

5 (2) 18 V.S.A. chapter 221, subchapter 9 (§§ 9471–9474; pharmacy

6 benefit managers).

7 Sec. 6. APPLICABILITY

8 (a)**(1)** The provisions of Sec. 1 of this act (18 V.S.A. chapter 77, pharmacy

9 benefit managers) **relating to contracting and to benefit design** shall apply to

10 a contract or health benefit plan issued, offered, renewed, recredentialed,

11 amended, or extended on or after January 1, 202**5**, including any health insurer

12 that performs claims processing or other prescription drug or device services

13 through a third party**, but in no event later than July 1, 2029**.

14 **(2)** At least annually **through 2029**, a pharmacy benefit manager that

15 provides pharmacy benefit management for a health benefit plan **and uses**

16 **spread pricing** shall disclose to the health insurer, the Department of Financial

17 Regulation, the Green Mountain Care Board, and the Office of the Health Care

18 Advocate the aggregate amount the pharmacy benefit manager retained on all

19 claims charged to the health insurer for prescriptions filled during the

20 preceding calendar year in excess of the amount the pharmacy benefit manager

21 reimbursed pharmacies.

1 (b) A person doing business in this State as a pharmacy benefit manager on
2 or before January 1, 202**5** shall have ~~six~~ **12** months following that date to come
3 into compliance with the **licensure** provisions of Sec. 1 of this act (18 V.S.A.
4 chapter 77, pharmacy benefit managers).
5 Sec. 7. EFFECTIVE DATE
6 This act shall take effect on July 1, 202**4**.
7
8
9
10
11
12 (Committee vote: ___________)
13 _______________________
14 Representative ___________
15 FOR THE COMMITTEE