

1 H.353

2 Introduced by Representative Cordes of Lincoln

3 Referred to Committee on

4 Date:

5 Subject: Health; health insurance; prescription drugs; pharmacies; pharmacy
6 benefit managers

7 Statement of purpose of bill as introduced: This bill proposes to require
8 pharmacy benefit managers to obtain licensure from, rather than register with,
9 the Department of Financial Regulation. It would establish a detailed
10 regulatory framework for regulating pharmacy benefit managers and would
11 prohibit or restrict a number of pharmacy benefit management activities. The
12 bill would recodify most of the existing statutory provisions relating to
13 pharmacy benefit managers in one chapter, with some revisions. It would
14 allow health insurance plan beneficiaries to choose their own pharmacies, limit
15 direct solicitation by pharmacies and pharmacy benefit managers, and provide
16 pharmacies with additional rights during an audit. The bill would also require
17 the Agency of Human Services to select a wholesale drug distributor through a
18 competitive bidding process to be the sole source to distribute prescription
19 drugs to pharmacies for dispensing to Medicaid beneficiaries.

20 An act relating to pharmacy benefit management

1 It is hereby enacted by the General Assembly of the State of Vermont:

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

3 CHAPTER 77. PHARMACY BENEFIT MANAGERS

4 Subchapter 1. General Provisions

5 § 3601. PURPOSE

6 The purpose of this chapter is to establish standards and criteria for the
7 licensure and regulation of pharmacy benefit managers providing claims
8 processing services or other prescription drug or device services for health
9 benefit plans by:

10 (1) promoting, preserving, and protecting the public health, safety, and
11 welfare through effective regulation and licensure of pharmacy benefit
12 managers;

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

17 (3) providing for the powers and duties of the Commissioner of
18 Financial Regulation; and

19 (4) prescribing penalties and fines for violations of this chapter.

20 § 3602. DEFINITIONS

21 As used in this chapter:

1 (1) “Claims processing services” means the administrative services
2 performed in connection with the processing and adjudicating of claims
3 relating to pharmacist services that include receiving payments for pharmacist
4 services or making payments to pharmacists or pharmacies for pharmacy
5 services, or both.

6 (2) “Commissioner” means the Commissioner of Financial Regulation.

7 (3) “Covered person” means a member, policyholder, subscriber,
8 enrollee, beneficiary, dependent, or other individual participating in a health
9 benefit plan.

10 (4) “Health benefit plan” means a policy, contract, certificate, or
11 agreement entered into, offered, or issued by a health insurer to provide,
12 deliver, arrange for, pay for, or reimburse any of the costs of physical, mental,
13 or behavioral health care services.

14 (5) “Health insurer” has the same meaning as in section 9402 of this title
15 and includes:

16 (A) health insurance companies, nonprofit hospital and medical
17 service corporations, and health maintenance organizations;

18 (B) employers, labor unions, and other group of persons organized in
19 Vermont that provide a health benefit plan to beneficiaries who are employed
20 or reside in Vermont;

1 (C) the State of Vermont and any agent or instrumentality of the State
2 that offers, administers, or provides financial support to State government; and

3 (D) Medicaid and any other public health care assistance program.

4 (6) “Maximum allowable cost” means the per unit drug product
5 reimbursement amount, excluding dispensing fees, for a group of equivalent
6 multisource prescription drugs.

7 (7) “Other prescription drug or device services” means services other
8 than claims processing services provided directly or indirectly, whether in
9 connection with or separate from claims processing services, and may include:

10 (A) negotiating rebates, discounts, or other financial incentives and
11 arrangements with drug companies;

12 (B) disbursing or distributing rebates;

13 (C) managing or participating in incentive programs or arrangements
14 for pharmacist services;

15 (D) negotiating or entering into contractual arrangements with
16 pharmacists or pharmacies, or both;

17 (E) developing and maintaining formularies;

18 (F) designing prescription benefit programs; and

19 (G) advertising or promoting services.

20 (8) “Pharmacist” means an individual licensed as a pharmacist pursuant
21 to 26 V.S.A. chapter 36.

1 (9) “Pharmacist services” means products, goods, and services, or a
2 combination of these, provided as part of the practice of pharmacy.

3 (10) “Pharmacy” means a place licensed by the Vermont Board of
4 Pharmacy at which drugs, chemicals, medicines, prescriptions, and poisons are
5 compounded, dispensed, or sold at retail.

6 (11) “Pharmacy benefit management” means an arrangement for the
7 procurement of prescription drugs at a negotiated rate for dispensation within
8 this State to beneficiaries, the administration or management of prescription
9 drug benefits provided by a health benefit plan for the benefit of beneficiaries,
10 or any of the following services provided with regard to the administration of
11 pharmacy benefits:

12 (A) mail service pharmacy;

13 (B) claims processing, retail network management, and payment of
14 claims to pharmacies for prescription drugs dispensed to beneficiaries;

15 (C) clinical formulary development and management services;

16 (D) rebate contracting and administration;

17 (E) certain patient compliance, therapeutic intervention, and generic
18 substitution programs; and

19 (F) disease or chronic care management programs.

20 (12)(A) “Pharmacy benefit manager” means an individual, corporation,
21 or other entity, including a wholly or partially owned or controlled subsidiary

1 of a pharmacy benefit manager, that provides pharmacy benefit management
2 services for health benefit plans.

3 (B) The term “pharmacy benefit manager” does not include:

4 (i) a health care facility licensed in this State;

5 (ii) a health care professional licensed in this State;

6 (iii) a consultant who only provides advice as to the selection or
7 performance of a pharmacy benefit manager; or

8 (iv) a health insurer to the extent that it performs any claims
9 processing and other prescription drug or device services exclusively for its
10 enrollees.

11 § 3603. RULEMAKING

12 The Commissioner of Financial Regulation may adopt rules in accordance
13 with 3 V.S.A. chapter 25 to carry out the provisions of this chapter. The rules
14 shall include, as appropriate, requirements that health insurers maintain the
15 confidentiality of proprietary information.

16 § 3604. REPORTING

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

1 Subchapter 2. Pharmacy Benefit Manager Licensure and Regulation

2 § 3611. LICENSURE

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

6 (b) A person applying for a pharmacy benefit manager license shall submit
7 an application for licensure in the form and manner prescribed by the
8 Commissioner and shall include with the application a nonrefundable
9 application fee of \$100.00 and a licensure fee of \$500.00.

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

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

20 (1) Continues to do business in this State.

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

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

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

11 § 3612. PROHIBITED PRACTICES

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

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

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

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

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

1 (5) information on finance incentives and structures used by the health
2 insurer.

3 (b) A pharmacy benefit manager shall not prohibit a pharmacy or
4 pharmacist from:

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

7 (2) providing information to a covered person regarding the covered
8 person's cost-sharing amount for a prescription drug;

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

11 (4) selling a more affordable alternative to the covered person if a more
12 affordable alternative is available.

13 (c) A pharmacy benefit manager contract with a participating pharmacist or
14 pharmacy shall not prohibit, restrict, or limit disclosure of information to the
15 Commissioner, law enforcement, or State and federal government officials,
16 provided that:

17 (1) the recipient of the information represents that the recipient has the
18 authority, to the extent provided by State or federal law, to maintain
19 proprietary information as confidential; and

20 (2) prior to disclosure of information designated as confidential, the
21 pharmacist or pharmacy:

1 (A) marks as confidential any document in which the information
2 appears; and

3 (B) requests confidential treatment for any oral communication of the
4 information.

5 (d) A pharmacy benefit manager shall not terminate a contract with or
6 penalize a pharmacist or pharmacy due to the pharmacist or pharmacy:

7 (1) disclosing information about pharmacy benefit manager practices,
8 except for information determined to be a trade secret under State law or by the
9 Commissioner, when disclosed in a manner other than in accordance with
10 subsection (c) of this section; or

11 (2) sharing any portion of the pharmacy benefit manager contract with
12 the Commissioner pursuant to a complaint or query regarding the contract's
13 compliance with the provisions of this chapter.

14 (e)(1) A pharmacy benefit manager shall not require a covered person
15 purchasing a covered prescription drug to pay an amount greater than the lesser
16 of:

17 (A) the cost-sharing amount under the terms of the health benefit
18 plan;

19 (B) the maximum allowable cost for the drug; or

1 (C) the amount the covered person would pay for the drug, after
2 application of any known discounts, if the covered person were paying the cash
3 price.

4 (2) Any amount paid by a covered person under subdivision (1) of this
5 subsection shall be attributed toward any deductible, to the extent consistent
6 with Sec. 2707 of the Public Health Service Act (42 U.S.C. § 300gg-6), the
7 annual out-of-pocket maximums under the covered person's health benefit
8 plan.

9 (f) A pharmacy benefit manager shall not conduct or participate in spread
10 pricing in this State.

11 § 3613. ENFORCEMENT

12 (a) The Commissioner of Financial Regulation shall enforce compliance
13 with the provisions of this chapter.

14 (b)(1) The Commissioner may examine or audit the books and records of a
15 pharmacy benefit manager providing claims processing services or other
16 prescription drug or device services for a health benefit plan to determine
17 compliance with this chapter.

18 (2) Information or data acquired in the course of an examination or audit
19 under subdivision (1) of this subsection shall be considered proprietary and
20 confidential, shall be exempt from public inspection and copying under the

1 Public Records Act, shall not be subject to subpoena, and shall not be subject
2 to discovery or admissible in evidence in any private civil action.

3 (c) The Commissioner may use any document or information provided
4 pursuant to subsection 3612 (c) or (d) of this chapter in the performance of the
5 Commissioner's duties to determine compliance with this chapter.

6 (d) The Commissioner may impose a penalty on a pharmacy benefit
7 manager or the health insurer with which it is contracted, or both, for a
8 violation of this chapter. The penalty shall be not less than \$25,000.00 nor
9 more than \$50,000.00 for each violation of this chapter.

10 § 3614. COMPLIANCE; CONSISTENCY WITH FEDERAL LAW

11 Nothing in this chapter is intended or should be construed to conflict with
12 applicable federal law.

13 § 3615. CHARGES FOR EXAMINATIONS, APPLICATIONS, REVIEWS,

14 AND INVESTIGATIONS

15 (a) The Department of Financial Regulation may charge its reasonable
16 expenses in administering the provisions of this chapter to pharmacy benefit
17 managers in the manner provided for in 8 V.S.A. § 18. These expenses shall
18 be allocated in proportion to the lives of Vermonters covered by each
19 pharmacy benefit manager as reported annually to the Commissioner in a
20 manner and form prescribed by the Commissioner.

1 (b) The Department of Financial Regulation shall not charge its expenses to
2 the pharmacy benefit manager contracting with the Department of Vermont
3 Health Access if the Department of Vermont Health Access notifies the
4 Department of Financial Regulation of the conditions contained in its contract
5 with a pharmacy benefit manager.

6 Subchapter 3. Pharmacy Benefit Manager Relations with Health Insurers

7 § 3621. INSURER AUDIT OF PHARMACY BENEFIT MANAGER

8 ACTIVITIES

9 In order to enable periodic verification of pricing arrangements in
10 administrative-services-only contracts, pharmacy benefit managers shall allow
11 access, in accordance with rules adopted by the Commissioner, by the health
12 insurer who is a party to the administrative-services-only contract to financial
13 and contractual information necessary to conduct a complete and independent
14 audit designed to verify the following:

15 (1) full pass through of negotiated drug prices and fees associated with
16 all drugs dispensed to beneficiaries of the health benefit plan in both retail and
17 mail order settings or resulting from any of the pharmacy benefit management
18 functions defined in the contract;

19 (2) full pass through of all financial remuneration associated with all
20 drugs dispensed to beneficiaries of the health benefit plan in both retail and

1 mail order settings or resulting from any of the pharmacy benefit management
2 functions defined in the contract; and

3 (3) any other verifications relating to the pricing arrangements and
4 activities of the pharmacy benefit manager required by the contract if required
5 by the Commissioner.

6 § 3622. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES

7 WITH RESPECT TO HEALTH INSURERS

8 (a) A pharmacy benefit manager that provides pharmacy benefit
9 management for a health benefit plan has a fiduciary duty to its health insurer
10 client that includes a duty to be fair and truthful toward the health insurer, to
11 act in the health insurer's best interests, and to perform its duties with care,
12 skill, prudence, and diligence. In the case of a health benefit plan offered by a
13 health insurer as defined by subdivision 3602(5)(A) of this title, the health
14 insurer shall remain responsible for administering the health benefit plan in
15 accordance with the health insurance policy or subscriber contract or plan and
16 in compliance with all applicable provisions of Title 8 and this title.

17 (b) A pharmacy benefit manager shall provide notice to the health insurer
18 that the terms contained in subsection (c) of this section may be included in the
19 contract between the pharmacy benefit manager and the health insurer.

20 (c) A pharmacy benefit manager that provides pharmacy benefit
21 management for a health plan shall do all of the following:

1 (1) Provide all financial and utilization information requested by a
2 health insurer relating to the provision of benefits to beneficiaries through that
3 health insurer's health benefit plan and all financial and utilization information
4 relating to services to that health insurer. A pharmacy benefit manager
5 providing information under this subsection may designate that material as
6 confidential. Information designated as confidential by a pharmacy benefit
7 manager and provided to a health insurer under this subsection shall not be
8 disclosed by the health insurer to any person without the consent of the
9 pharmacy benefit manager, except that disclosure may be made by the health
10 insurer:

11 (A) in a court filing under the consumer protection provisions of
12 9 V.S.A. chapter 63, provided that the information shall be filed under seal and
13 that prior to the information being unsealed, the court shall give notice and an
14 opportunity to be heard to the pharmacy benefit manager on why the
15 information should remain confidential;

16 (B) to State and federal government officials;

17 (C) when authorized by 9 V.S.A. chapter 63;

18 (D) when ordered by a court for good cause shown; or

19 (E) when ordered by the Commissioner as to a health insurer as
20 defined in subdivision 3602(5)(A) of this chapter pursuant to the provisions of
21 Title 8 and this title.

1 (2) Notify a health insurer in writing of any proposed or ongoing
2 activity, policy, or practice of the pharmacy benefit manager that presents,
3 directly or indirectly, any conflict of interest with the requirements of this
4 section.

5 (3) With regard to the dispensation of a substitute prescription drug for a
6 prescribed drug to a beneficiary in which the substitute drug costs more than
7 the prescribed drug and the pharmacy benefit manager receives a benefit or
8 payment directly or indirectly, disclose to the health insurer the cost of both
9 drugs and the benefit or payment directly or indirectly accruing to the
10 pharmacy benefit manager as a result of the substitution.

11 (4) If the pharmacy benefit manager derives any payment or benefit for
12 the dispensation of prescription drugs within the State based on volume of
13 sales for certain prescription drugs or classes or brands of drugs within the
14 State, pass that payment or benefit on in full to the health insurer.

15 (5) Disclose to the health insurer all financial terms and arrangements
16 for remuneration of any kind that apply between the pharmacy benefit manager
17 and any prescription drug manufacturer that relate to benefits provided to
18 beneficiaries under or services to the health insurer's health benefit plan,
19 including formulary management and drug-switch programs, educational
20 support, claims processing, and pharmacy network fees charged from retail
21 pharmacies and data sales fees. A pharmacy benefit manager providing

1 information under this subsection may designate that material as confidential.
2 Information designated as confidential by a pharmacy benefit manager and
3 provided to a health insurer under this subsection shall not be disclosed by the
4 health insurer to any person without the consent of the pharmacy benefit
5 manager, except that disclosure may be made by the health insurer:

6 (A) in a court filing under the consumer protection provisions of
7 9 V.S.A. chapter 63, provided that the information shall be filed under seal and
8 that prior to the information being unsealed, the court shall give notice and an
9 opportunity to be heard to the pharmacy benefit manager on why the
10 information should remain confidential;

11 (B) when authorized by 9 V.S.A. chapter 63;

12 (C) when ordered by a court for good cause shown; or

13 (D) when ordered by the Commissioner as to a health insurer as
14 defined in subdivision 3602(5)(A) of this title pursuant to the provisions of
15 Title 8 and this title.

16 (d) A pharmacy benefit manager contract with a health insurer shall not
17 contain any provision purporting to reserve discretion to the pharmacy benefit
18 manager to move a drug to a higher tier or remove a drug from its drug
19 formulary any more frequently than two times per year.

20 (e) At least annually, a pharmacy benefit manager that provides pharmacy
21 benefit management for a health benefit plan shall disclose to the health

1 insurer, the Department of Financial Regulation, and the Green Mountain Care
2 Board the aggregate amount the pharmacy benefit manager retained on all
3 claims charged to the health insurer for prescriptions filled during the
4 preceding calendar year in excess of the amount the pharmacy benefit manager
5 reimbursed pharmacies.

6 (f) Compliance with the requirements of this section is required for
7 pharmacy benefit managers entering into contracts with a health insurer in this
8 State for pharmacy benefit management in this State.

9 Subchapter 4. Pharmacy Benefit Manager Relations with Pharmacies

10 § 3631. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES

11 WITH RESPECT TO PHARMACIES

12 (a) Within 14 calendar days following receipt of a pharmacy claim, a
13 pharmacy benefit manager or other entity paying pharmacy claims shall do one
14 of the following:

15 (1) Pay or reimburse the claim.

16 (2) Notify the pharmacy in writing that the claim is contested or denied.

17 The notice shall include specific reasons supporting the contest or denial and a
18 description of any additional information required for the pharmacy benefit
19 manager or other payer to determine liability for the claim.

20 (b) In addition to the practices prohibited by section 3612 of this chapter, a
21 pharmacy benefit manager or other entity paying pharmacy claims shall not

1 require a pharmacy to pass through any portion of the insured's co-payment, or
2 patient responsibility, to the pharmacy benefit manager or other payer.

3 (c) For each drug for which a pharmacy benefit manager establishes a
4 maximum allowable cost in order to determine the reimbursement rate, the
5 pharmacy benefit manager shall do all of the following:

6 (1) Make available, in a format that is readily accessible and
7 understandable by a pharmacist, the actual maximum allowable cost for each
8 drug and the source used to determine the maximum allowable cost, which
9 shall not be dependent upon individual beneficiary identification or benefit
10 stage.

11 (2) Update the maximum allowable cost at least once every seven
12 calendar days. In order to be subject to maximum allowable cost, a drug must
13 be widely available for purchase by all pharmacies in the State, without
14 limitations, from national or regional wholesalers and must not be obsolete or
15 temporarily unavailable.

16 (3) Establish or maintain a reasonable administrative appeals process to
17 allow a dispensing pharmacy provider to contest a listed maximum allowable
18 cost.

19 (4)(A) Respond in writing to any appealing pharmacy provider within
20 10 calendar days after receipt of an appeal, provided that, except as provided in
21 subdivision (B) of this subdivision (4), a dispensing pharmacy provider shall

1 file any appeal within 10 calendar days from the date its claim for
2 reimbursement is adjudicated.

3 (B) A pharmacy benefit manager shall allow a dispensing pharmacy
4 provider to appeal after the 10-calendar-day appeal period set forth in
5 subdivision (A) of this subdivision (4) if the prescription claim is subject to an
6 audit initiated by the pharmacy benefit manager or its auditing agent.

7 (5) For a denied appeal, provide the reason for the denial and identify
8 the national drug code and a Vermont-licensed wholesaler of an equivalent
9 drug product that may be purchased by contracted pharmacies at or below the
10 maximum allowable cost.

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

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

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

16 (d) If a pharmacy benefit manager denies a pharmacy's or pharmacist's
17 appeal in whole or in part and the reimbursement amount is less than the
18 pharmacy's reasonable acquisition cost plus a dispensing fee, the pharmacy or
19 pharmacist may submit a claim to the health insurer for the balance and the
20 health insurer shall reimburse the pharmacy or pharmacist that amount.

1 (e) A pharmacy benefit manager shall not reimburse a pharmacy or
2 pharmacist in this State an amount less than the amount the pharmacy benefit
3 manager reimburses a pharmacy benefit manager affiliate for providing the
4 same pharmacist services. The reimbursement amount shall be calculated on a
5 per unit basis based on the generic product identifier or generic code number
6 and shall include a professional dispensing fee that shall be not less than the
7 professional dispensing fee established for the Vermont Medicaid program by
8 the Department of Vermont Health Access in accordance with 42 C.F.R.
9 Part 447.

10 (f) A pharmacy benefit manager shall not restrict, limit, or impose
11 requirements on a licensed pharmacy in excess of those set forth by the
12 Vermont Board of Pharmacy or by other State or federal law, nor shall it
13 withhold reimbursement for services on the basis of noncompliance with
14 participation requirements.

15 (g) A pharmacy benefit manager shall provide notice to all participating
16 pharmacies prior to changing its drug formulary.

17 (h)(1) A pharmacy benefit manager or other third party that reimburses a
18 340B covered entity for drugs that are subject to an agreement under 42 U.S.C.
19 § 256b through the 340B drug pricing program shall not reimburse the 340B
20 covered entity for pharmacy-dispensed drugs at a rate lower than that paid for
21 the same drug to pharmacies that are not 340B covered entities, and the

1 pharmacy benefit manager shall not assess any fee, charge-back, or other
2 adjustment on the 340B covered entity on the basis that the covered entity
3 participates in the 340B program as set forth in 42 U.S.C. § 256b.

4 (2) With respect to a patient who is eligible to receive drugs that are
5 subject to an agreement under 42 U.S.C. § 256b through the 340B drug pricing
6 program, a pharmacy benefit manager or other third party that makes payment
7 for the drugs shall not discriminate against a 340B covered entity in a manner
8 that prevents or interferes with the patient's choice to receive the drugs from
9 the 340B covered entity.

10 Sec. 2. 18 V.S.A. § 3802 is amended to read:

11 § 3802. PHARMACY RIGHTS DURING AN AUDIT

12 Notwithstanding any provision of law to the contrary, whenever a health
13 insurer, a third-party payer, or an entity representing a responsible party
14 conducts an audit of the records of a pharmacy, the pharmacy shall have a right
15 to all of the following:

16 * * *

17 (2) If an audit is to be conducted on-site at a pharmacy, the entity
18 conducting the audit:

19 (A) shall give the pharmacy at least 14 days' advance written notice
20 of the audit and the specific prescriptions to be included in the audit; ~~and~~

1 (B) ~~may~~ shall not audit a pharmacy on Mondays or on weeks
2 containing a federal holiday, unless the pharmacy agrees to alternative timing
3 for the audit; and

4 ~~(3) Not to have an entity~~

5 (C) shall not audit claims that:

6 ~~(A)(i)~~ were submitted to the pharmacy benefit manager more than
7 18 months prior to the date of the audit, unless:

8 ~~(i)(I)~~ required by federal law; or

9 ~~(ii)(II)~~ the originating prescription was dated within the 24-
10 month period preceding the date of the audit; or

11 ~~(B)(ii)~~ exceed 200 selected prescription claims.

12 (3) If any audit is to be conducted remotely, the entity conducting the
13 audit:

14 (A) shall give the pharmacy at least seven business days following
15 the pharmacy's confirmation of receipt of the notice of the audit to respond to
16 the audit; and

17 (B) shall not audit claims that:

18 (i) were submitted to the pharmacy benefit manager more than
19 three months prior to the date of the audit or on a date earlier than that for

20 which the pharmacy could electronically retransmit a corrected claim; or

21 (ii) exceed five selected prescription claims.

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(19) To have the preliminary audit report delivered to the pharmacy within ~~60~~ 30 days following the ~~conclusion of the audit~~ pharmacy's preliminary response.

* * *

(21) To have a final audit report delivered to the pharmacy within ~~120~~ 30 days after the end of the appeals period, as required by section 3803 of this title.

* * *

(24) To have all payment data related to audited claims, including:

(A) payment amount;

(B) any direct and indirect remuneration (DIR) or generic effective rate (GER) fees assessed or other financial offsets;

(C) date of electronic payment or check date and number;

(D) the specific contracted reimbursement basis for each claim, including its basis, such as maximum allowable cost (MAC), wholesale acquisition cost (WAC), average wholesale price (AWP), or average manufacturer price (AMP); and

(E) the respective values used to calculate each claim payment.

1 Sec. 3. 8 V.S.A. § 4089j is amended to read:

2 § 4089j. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS

3 (a) As used in this section:

4 * * *

5 (4) “Direct solicitation” means direct contact, including telephone,
6 computer, e-mail, instant messaging, or in-person contact, by a pharmacy
7 provider or its agent to a beneficiary of a plan offered by a health insurer
8 without the beneficiary’s consent for the purpose of marketing the pharmacy
9 provider’s services.

10 * * *

11 (d)(1) A health insurer or pharmacy benefit manager shall permit a
12 beneficiary of a plan offered by the health insurer to fill a prescription at the
13 pharmacy of the beneficiary’s choice and shall not impose differential cost-
14 sharing requirements based on the choice of pharmacy or otherwise promote
15 the use of one pharmacy over another.

16 (2) A health insurer or pharmacy benefit manager shall permit a
17 participating network pharmacy to perform all pharmacy services within the
18 lawful scope of the profession of pharmacy as set forth in 26 V.S.A.
19 chapter 36.

20 (3) A health insurer or pharmacy benefit manager shall adhere to the
21 definitions of prescription drugs and the requirements and guidance regarding

1 the pharmacy profession established by State and federal law and the Vermont
2 Board of Pharmacy and shall not establish classifications of or distinctions
3 between prescription drugs, impose penalties on prescription drug claims,
4 attempt to dictate the behavior of pharmacies or pharmacists, or place
5 restrictions on pharmacies or pharmacists that are more restrictive than or
6 inconsistent with State or federal law or with rules adopted or guidance
7 provided by the Board of Pharmacy.

8 (4) A pharmacy benefit manager or licensed pharmacy shall not make a
9 direct solicitation to the beneficiary of a plan offered by a health insurer unless
10 one or more of the following applies:

11 (A) the beneficiary has given written permission to the supplier or the
12 ordering health care professional to contact the beneficiary regarding the
13 furnishing of a prescription item that is to be rented or purchased;

14 (B) the supplier has furnished a prescription item to the beneficiary
15 and is contacting the beneficiary to coordinate delivery of the item; or

16 (C) if the contact relates to the furnishing of a prescription item other
17 than a prescription item already furnished to the beneficiary, the supplier has
18 furnished at least one prescription item to the beneficiary within the 15-month
19 period preceding the date on which the supplier attempts to make the contact.

1 Sec. 4. 33 V.S.A. § 2011 is added to read:

2 § 2011. WHOLESALE DRUG DISTRIBUTOR CONTRACT

3 (a) As used in this section:

4 (1) “Dead net cost” means the wholesale acquisition cost of a
5 prescription drug, less any applicable discounts and all vendor rebates, fees,
6 and incentives, including inventory management agreement fees, fee-for-
7 service agreements, volume incentives, rebates, and reporting fees.

8 (2) “Wholesale drug distributor” has the same meaning as “wholesale
9 distributor” in 26 V.S.A. § 2022.

10 (b) The Agency of Human Services shall establish a competitive bidding
11 process for a wholesale drug distributor, or for several wholesale drug
12 distributors through a group purchasing organization, through which the
13 selected wholesaler or group purchasing organization shall be the sole source
14 to distribute prescription drugs to the community and outpatient pharmacies
15 with which the wholesaler or group purchasing organization enters into
16 contracts for prescription drugs dispensed to beneficiaries of Medicaid and
17 other State health assistance programs for which the Department of Vermont
18 Health Access pays pharmaceutical claims. The Agency of Human Services
19 shall convene a group comprising one representative each from the Green
20 Mountain Care Board, the Department of Vermont Health Access, the
21 Vermont Board of Pharmacy, the Vermont Association of Chain Drug Stores,

1 and the Vermont Community Pharmacy Network to conduct the competitive
2 bidding process and to select the wholesale drug distributor or group
3 purchasing organization that the group determines:

4 (1) will offer the greatest cost savings to the Department of Vermont
5 Health Access;

6 (2) will provide complete transparency; and

7 (3) demonstrates a willingness to facilitate additional savings throughout
8 the State by expanding the program to additional public and private purchasers.

9 (c) The wholesale drug distributor or group purchasing organization
10 selected pursuant to subsection (b) of this section shall:

11 (1) establish contracts with all Medicaid-participating community and
12 outpatient pharmacies operating in this State;

13 (2) maintain compliance with all applicable federal and State statutes,
14 rules, and regulations relating to the operation of a wholesale drug distributor
15 or group purchasing organization;

16 (3) segregate the commercial portion of its pharmacy business from the
17 Vermont Medicaid portion;

18 (4) match the Department of Vermont Health Access's reports of claims
19 paid per pharmacy with the pharmacies' invoices;

20 (5) invoice the Department of Vermont Health Access in an amount
21 equal to the aggregate sum of the wholesaler's or group purchasing

1 organization's dead net costs for all claims dispensed during a given period
2 across all participating pharmacies;

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

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

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

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

1 Sec. 5. REPEALS

2 The following are repealed on July 1, 2021:

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) The provisions of Sec. 1 of this act (18 V.S.A. chapter 77, pharmacy
9 benefit managers) shall apply to a contract or health benefit plan issued,
10 offered, renewed, recredentialed, amended, or extended on or after the
11 effective date of this act, including any health insurer that performs claims
12 processing or other prescription drug or device services through a third party.

13 (b) A person doing business in this State as a pharmacy benefit manager on
14 or before the effective date of this act shall have six months following the
15 effective date of this act to come into compliance with the provisions of Sec. 1
16 of this act (18 V.S.A. chapter 77, pharmacy benefit manager licensure and
17 regulation).

18 Sec. 7. EFFECTIVE DATE

19 This act shall take effect on July 1, 2021.