1 TO THE HONORABLE SENATE:

2 The Committee on Health and Welfare to which was referred House Bill
3 No. 353 entitled "An act relating to pharmacy benefit management"
4 respectfully reports that it has considered the same and recommends that the
5 Senate propose to the House that the bill be amended by striking out all after
6 the enacting clause and inserting in lieu thereof the following:

7 Sec. 1. INTENT

8 It is the intent of the General Assembly to increase access to needed
9 medications by making prescription drugs more affordable and accessible to
10 Vermonters by increasing State regulation of pharmacy benefit managers and
11 pharmacy benefit management. It is also the intent of the General Assembly to
12 stabilize and safeguard against the loss of more independent and community
13 pharmacies, where pharmacists provide personalized care to Vermonters and
14 help them with their health care needs, including medication management,
15 medication adherence, and health screenings.

16 Sec. 1a. 18 V.S.A. § 9421 is amended to read:

17 § 9421. PHARMACY BENEFIT MANAGEMENT; REGISTRATION;
18 INSURER AUDIT OF PHARMACY BENEFIT MANAGER
19 ACTIVITIES

20 * * *

1 (f) The Department of Financial Regulation shall monitor the cost
2 impacts on Vermont consumers of pharmacy benefit manager regulation
3 pursuant to this section and to subchapter 9 of this chapter and shall
4 recommend appropriate modifications to the laws as needed to promote health
5 care affordability in this State.
6 (g) As used in this section:
7 * * *
8 Sec. 2. 18 V.S.A. chapter 221, subchapter 9 is amended to read:
9 Subchapter 9. Pharmacy Benefit Managers
10 § 9471. DEFINITIONS
11 As used in this subchapter:
12 * * *
13 (2) "Health insurer" is defined by section 9402 of this title and shall
14 include:
15 (A) a health insurance company, a nonprofit hospital and medical
16 service corporation, and health maintenance organizations;
17 (B) an employer, labor union, or other group of persons organized in
18 Vermont that provides a health plan to beneficiaries who are employed or
19 reside in Vermont; and
20 (C) the State of Vermont and any agent or instrumentality of the State
21 that offers, administers, or provides financial support to State government; and

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

* * *

(7) "Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that, directly or indirectly, through one or more intermediaries, is owned or controlled by, or is under common ownership or control with, a pharmacy benefit manager.

§ 9472. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO HEALTH INSURERS AND COVERED PERSONS

(a) A pharmacy benefit manager that provides pharmacy benefit management for a health plan ~~shall discharge its duties with reasonable care and diligence and be fair and truthful under the circumstances then prevailing that a pharmacy benefit manager acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims~~ has a fiduciary duty to its health insurer client that includes a duty to be fair and truthful toward the health insurer, to act in the health insurer's best interests, and to perform its duties with care, skill, prudence, and diligence. In the case of a health benefit plan offered by a health insurer as defined by subdivision 9471(2)(A) of this title, the health insurer shall remain responsible for administering the health benefit plan in accordance with the health

1 insurance policy or subscriber contract or plan and in compliance with all
2 applicable provisions of Title 8 and this title.
3 (b) A pharmacy benefit manager shall provide notice to the health insurer
4 that the terms contained in subsection (c) of this section may be included in the
5 contract between the pharmacy benefit manager and the health insurer.
6 (c) A pharmacy benefit manager that provides pharmacy benefit
7 management for a health plan shall do all of the following:
8 (1) Provide all financial and utilization information requested by a
9 health insurer relating to the provision of benefits to beneficiaries through that
10 health insurer's health plan and all financial and utilization information
11 relating to services to that health insurer. A pharmacy benefit manager
12 providing information under this subsection may designate that material as
13 confidential. Information designated as confidential by a pharmacy benefit
14 manager and provided to a health insurer under this subsection ~~may~~ shall not
15 be disclosed by the health insurer to any person without the consent of the
16 pharmacy benefit manager, except that disclosure may be made by the health
17 insurer:
18 (A) in a court filing under the consumer protection provisions of
19 9 V.S.A. chapter 63, provided that the information shall be filed under seal and
20 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) to State and federal government officials;
4 (C) when authorized by 9 V.S.A. chapter 63;
5 ~~(C)~~(D) when ordered by a court for good cause shown; or
6 ~~(D)~~(E) when ordered by the Commissioner as to a health insurer as
7 defined in subdivision 9471(2)(A) of this title pursuant to the provisions of
8 Title 8 and this title.
9 (2) Notify a health insurer in writing of any proposed or ongoing
10 activity, policy, or practice of the pharmacy benefit manager that presents,
11 directly or indirectly, any conflict of interest with the requirements of this
12 section.
13 (3) With regard to the dispensation of a substitute prescription drug for a
14 prescribed drug to a beneficiary in which the substitute drug costs more than
15 the prescribed drug and the pharmacy benefit manager receives a benefit or
16 payment directly or indirectly, disclose to the health insurer the cost of both
17 drugs and the benefit or payment directly or indirectly accruing to the
18 pharmacy benefit manager as a result of the substitution.
19 (4) ~~Unless the contract provides otherwise, if~~ If the pharmacy benefit
20 manager derives any payment or benefit for the dispensation of prescription
21 drugs within the State based on volume of sales for certain prescription drugs

or classes or brands of drugs within the State, pass that payment or benefit on in full to the health insurer.

(5) Disclose to the health insurer all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefit manager and any prescription drug manufacturer that relate to benefits provided to beneficiaries under or services to the health insurer’s health plan, including formulary management and drug-switch programs, educational support, claims processing, and pharmacy network fees charged from retail pharmacies and data sales fees. A pharmacy benefit manager providing information under this subsection may designate that material as confidential. Information designated as confidential by a pharmacy benefit manager and provided to a health insurer under this subsection ~~may~~ shall not be disclosed by the health insurer to any person without the consent of the pharmacy benefit manager, except that disclosure may be made by the health insurer:

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

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

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

1 (D) when ordered by the Commissioner as to a health insurer as
2 defined in subdivision 9471(2)(A) of this title pursuant to the provisions of
3 Title 8 and this title.
4 (d) At least annually, a pharmacy benefit manager that provides pharmacy
5 benefit management for a health plan shall disclose to the health insurer, the
6 Department of Financial Regulation, and the Green Mountain Care Board the
7 aggregate amount the pharmacy benefit manager retained on all claims charged
8 to the health insurer for prescriptions filled during the preceding calendar year
9 in excess of the amount the pharmacy benefit manager reimbursed pharmacies.
10 (e) A pharmacy benefit manager contract with a health insurer shall not
11 contain any provision purporting to reserve discretion to the pharmacy benefit
12 manager to move a drug to a higher tier or remove a drug from its drug
13 formulary any more frequently than two times per year.
14 (f)(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 and, to the extent
6 consistent with Sec. 2707 of the Public Health Service Act (42 U.S.C.
7 § 300gg-6), the annual out-of-pocket maximums under the covered person's
8 health benefit plan.
9 (g) Compliance with the requirements of this section is required for
10 pharmacy benefit managers entering into contracts with a health insurer in this
11 State for pharmacy benefit management in this State.
12 § 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES
13 WITH RESPECT TO PHARMACIES
14 (a) Within 14 calendar days following receipt of a pharmacy claim, a
15 pharmacy benefit manager or other entity paying pharmacy claims shall do one
16 of the following:
17 (1) Pay or reimburse the claim.
18 (2) Notify the pharmacy in writing that the claim is contested or denied.
19 The notice shall include specific reasons supporting the contest or denial and a
20 description of any additional information required for the pharmacy benefit
21 manager or other payer to determine liability for the claim.

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

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

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

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

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

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

(c) A pharmacy benefit manager or other entity paying pharmacy claims shall not:

(1) ~~impose a higher co-payment for a prescription drug than the co-payment applicable to the type of drug purchased under the insured's health plan;~~

~~(2) impose a higher co-payment for a prescription drug than the maximum allowable cost for the drug;~~

~~(3)~~ require a pharmacy to pass through any portion of the insured's co-payment, or patient responsibility, to the pharmacy benefit manager or other payer;

1 (2) prohibit a pharmacy or pharmacist from discussing information
2 regarding the total cost for pharmacist services for a prescription drug;
3 ~~(4)~~(3) prohibit or penalize a pharmacy or pharmacist for providing
4 information to an insured regarding the insured's cost-sharing amount for a
5 prescription drug; or
6 ~~(5)~~(4) prohibit or penalize a pharmacy or pharmacist for the pharmacist
7 or other pharmacy employee disclosing to an insured the cash price for a
8 prescription drug or selling a lower cost drug to the insured if one is available.
9 (d) A pharmacy benefit manager contract with a participating pharmacist or
10 pharmacy shall not prohibit, restrict, or limit disclosure of information to the
11 Commissioner, law enforcement, or State and federal government officials,
12 provided that:
13 (1) the recipient of the information represents that the recipient has the
14 authority, to the extent provided by State or federal law, to maintain
15 proprietary information as confidential; and
16 (2) prior to disclosure of information designated as confidential, the
17 pharmacist or pharmacy:
18 (A) marks as confidential any document in which the information
19 appears; and
20 (B) requests confidential treatment for any oral communication of the
21 information.

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

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

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

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

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

(2) Update the maximum allowable cost at least once every seven calendar days. In order to be subject to maximum allowable cost, a drug must be widely available for purchase by all pharmacies in the State, without

1 limitations, from national or regional wholesalers and must not be obsolete or
2 temporarily unavailable.
3 (3) Establish or maintain a reasonable administrative appeals process to
4 allow a dispensing pharmacy provider to contest a listed maximum allowable
5 cost.
6 (4)(A) Respond in writing to any appealing pharmacy provider within
7 10 calendar days after receipt of an appeal, provided that, except as provided in
8 subdivision (B) of this subdivision (4), a dispensing pharmacy provider shall
9 file any appeal within 10 calendar days from the date its claim for
10 reimbursement is adjudicated.
11 (B) A pharmacy benefit manager shall allow a dispensing pharmacy
12 provider to appeal after the 10-calendar-day appeal period set forth in
13 subdivision (A) of this subdivision (4) if the prescription claim is subject to an
14 audit initiated by the pharmacy benefit manager or its auditing agent.
15 (5) For a denied appeal, provide the reason for the denial and identify
16 the national drug code and a Vermont-licensed wholesaler of an equivalent
17 drug product that may be purchased by contracted pharmacies at or below the
18 maximum allowable cost.
19 (6) For an appeal in which the appealing pharmacy is successful:
20 (A) make the change in the maximum allowable cost within 30
21 business days after the redetermination; and

1 (B) allow the appealing pharmacy or pharmacist to reverse and rebill
2 the claim in question.
3 ~~(d)~~(g) A pharmacy benefit manager shall not:
4 (1) require a claim for a drug to include a modifier or supplemental
5 transmission, or both, to indicate that the drug is a 340B drug unless the claim
6 is for payment, directly or indirectly, by Medicaid; or
7 (2) restrict access to a pharmacy network or adjust reimbursement rates
8 based on a pharmacy's participation in a 340B contract pharmacy arrangement.
9 (h)(1) A pharmacy benefit manager or other third party that reimburses a
10 340B covered entity for drugs that are subject to an agreement under 42 U.S.C.
11 § 256b through the 340B drug pricing program shall not reimburse the 340B
12 covered entity for pharmacy-dispensed drugs at a rate lower than that paid for
13 the same drug to pharmacies that are not 340B covered entities, and the
14 pharmacy benefit manager shall not assess any fee, charge-back, or other
15 adjustment on the 340B covered entity on the basis that the covered entity
16 participates in the 340B program as set forth in 42 U.S.C. § 256b.
17 (2) With respect to a patient who is eligible to receive drugs that are
18 subject to an agreement under 42 U.S.C. § 256b through the 340B drug pricing
19 program, a pharmacy benefit manager or other third party that makes payment
20 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 (i) A pharmacy benefit manager shall not reimburse a pharmacy or
4 pharmacist in this State an amount less than the amount the pharmacy benefit
5 manager reimburses a pharmacy benefit manager affiliate for providing the
6 same pharmacist services.
7 (j) A pharmacy benefit manager shall not restrict, limit, or impose
8 requirements on a licensed pharmacy in excess of those set forth by the
9 Vermont Board of Pharmacy or by other State or federal law, nor shall it
10 withhold reimbursement for services on the basis of noncompliance with
11 participation requirements.
12 (k) A pharmacy benefit manager shall provide notice to all participating
13 pharmacies prior to changing its drug formulary.
14 Sec. 3. 18 V.S.A. § 3802 is amended to read:
15 § 3802. PHARMACY RIGHTS DURING AN AUDIT
16 Notwithstanding any provision of law to the contrary, whenever a health
17 insurer, a third-party payer, or an entity representing a responsible party
18 conducts an audit of the records of a pharmacy, the pharmacy shall have a right
19 to all of the following:
20 * * *

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

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

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

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

(C) shall not audit claims that:

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

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

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

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

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

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

(B) shall not audit claims that:

(i) were submitted to the pharmacy benefit manager more than three months prior to the date of the audit or on a date earlier than that for which the pharmacy could electronically retransmit a corrected claim; or

(ii) exceed five selected prescription claims.

* * *

(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

1 acquisition cost (WAC), average wholesale price (AWP), or average
2 manufacturer price (AMP); and
3 (E) the respective values used to calculate each claim payment.
4 Sec. 4. 8 V.S.A. § 4089j is amended to read:
5 § 4089j. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS
6 (a) As used in this section:
7 * * *
8 (4) "Pharmacy benefit manager affiliate" means a pharmacy or
9 pharmacist that, directly or indirectly, through one or more intermediaries, is
10 owned or controlled by, or is under common ownership or control with, a
11 pharmacy benefit manager.
12 (5) "Drug" or "prescription drug" has the same meaning as "prescription
13 drug" in 26 V.S.A. § 2022 and includes:
14 (A) biological products, as defined in 18 V.S.A. § 4601;
15 (B) medications used to treat complex, chronic conditions, including
16 medications that require administration, infusion, or injection by a health care
17 professional;
18 (C) medications for which the manufacturer or the U.S. Food and
19 Drug Administration requires exclusive, restricted, or limited distribution; and
20 (D) medications with specialized handling, storage, or inventory
21 reporting requirements.

* * *

(b) A health insurer ~~and~~ or pharmacy benefit manager doing business in Vermont shall permit a retail pharmacist licensed under 26 V.S.A. chapter 36 to fill prescriptions for all prescription drugs in the same manner and at the same level of reimbursement as they are filled by ~~mail order pharmacies~~ any other pharmacist or pharmacy, including a mail-order pharmacy or a pharmacy benefit manager affiliate, with respect to the quantity of drugs or days' supply of drugs dispensed under each prescription.

(c) Notwithstanding any provision of a health insurance plan to the contrary, if a health insurance plan provides for payment or reimbursement that is within the lawful scope of practice of a pharmacist, the insurer may provide payment or reimbursement for the service when the service is provided by a pharmacist.

(d)(1) A health insurer or pharmacy benefit manager shall permit a beneficiary of a plan offered by the health insurer to fill a prescription for a drug at the in-network pharmacy of the beneficiary's choice and, except with respect to pharmacies owned or operated, or both, by a health care facility, as defined in 18 V.S.A. § 9432, shall not impose differential cost-sharing requirements based on the choice of pharmacy or otherwise promote the use of one pharmacy over another.

1 (2) A health insurer or pharmacy benefit manager shall permit a
2 participating network pharmacy to perform all pharmacy services within the
3 lawful scope of the profession of pharmacy as set forth in 26 V.S.A.
4 chapter 36.
5 (3) A health insurer or pharmacy benefit manager shall not do any of the
6 following:
7 (A) Require a covered individual, as a condition of payment or
8 reimbursement, to purchase pharmacist services, including prescription drugs,
9 exclusively through a mail-order pharmacy or a pharmacy benefit manager
10 affiliate.
11 (B) Offer or implement plan designs that require a covered individual
12 to use a mail-order pharmacy or a pharmacy benefit manager affiliate.
13 (C) Order a covered individual, orally or in writing, including
14 through online messaging, to use a mail-order pharmacy or a pharmacy benefit
15 manager affiliate.
16 (D) Establish network requirements that are more restrictive than or
17 inconsistent with State or federal law, rules adopted by the Board of Pharmacy,
18 or guidance provided by the Board of Pharmacy or by drug manufacturers that
19 operate to limit or prohibit a pharmacy or pharmacist from dispensing or
20 prescribing drugs.

1 (E) Offer or implement plan designs that increase plan or patient
2 costs if the covered individual chooses not to use a mail-order pharmacy or a
3 pharmacy benefit manager affiliate. The prohibition in this subdivision (E)
4 includes requiring a covered individual to pay the full cost for a prescription
5 drug when the covered individual chooses not to use a mail-order pharmacy or
6 a pharmacy benefit manager affiliate.
7 (4) The provisions of this subsection shall not apply to Medicaid.
8 Sec. 4a. 8 V.S.A. § 4089k is added to read:
9 § 4089k. PRESCRIPTION DRUGS DISPENSED BY HEALTH INSURER-
10 DESIGNATED PHARMACIES FOR ADMINISTRATION TO
11 PATIENTS IN A HEALTH CARE SETTING
12 (a) As used in this section:
13 (1) "Health care professional" means an individual licensed to practice
14 medicine under 26 V.S.A. chapter 23 or 33, an individual licensed as a
15 naturopathic physician pursuant to 26 V.S.A. chapter 81, an individual licensed
16 as a physician assistant under 26 V.S.A. chapter 31, or an individual licensed
17 as an advanced practice registered nurse under 26 V.S.A. chapter 28.
18 (2) "Health care setting" means a health care professional's office or a
19 hospital or clinic at which a health care professional practices.
20 (3) "Health insurer" has the same meaning as in 18 V.S.A. § 9402.

1 (b)(1) A health insurer shall not, by contract, written policy, or written
2 procedure, require that a pharmacy designated by the health insurer dispense a
3 medication directly to a patient with the expectation or intention that the
4 patient will transport the medication to a health care setting for administration
5 by a health care professional.
6 (2)(A) A health insurer may enter into an agreement with a health care
7 professional under which a pharmacy designated by the health insurer
8 dispenses one or more medications directly to a specific patient for the patient
9 to transport to a health care setting for the health care professional to
10 administer to the patient.
11 (B) A health insurer that enters into an agreement pursuant to this
12 subdivision (2) shall attest to the Department of Financial Regulation, in a
13 form and manner determined by the Department, that:
14 (i) the health insurer provides an expedited, patient-specific
15 exception process for cases in which the health care professional certifies that
16 it is unsafe for an individual patient to receive medication directly from the
17 health insurer-designated pharmacy;
18 (ii) the health insurer-designated pharmacy provides for same-day
19 delivery of medications to patients;
20 (iii) the health insurer-designated pharmacy is accredited by a
21 national pharmacy accreditation organization;

1 (iv) the health insurer-designated pharmacy has the ability to
2 deliver medications to the patient's home in a clinically appropriate dosage and
3 in a ready-to-administer form;
4 (v) the health insurer-designated pharmacy utilizes cold chain
5 logistics or other means to ensure that each medication remains at the
6 appropriate temperature through all stages of supply, storage, and delivery;
7 (vi) the health insurer-designated pharmacy provides a
8 medication's pedigree to certify to the health care professional that the
9 medication was handled appropriately throughout the supply chain;
10 (vii) the health insurer-designated pharmacy demonstrates
11 expertise and reliability in risk evaluation and mitigation strategy that comply
12 with U.S. Food and Drug Administration reporting requirements; and
13 (viii) the health insurer or the health insurer-designated pharmacy,
14 or both, make access to a pharmacist or nurse available 24 hours per day, seven
15 days per week.
16 (c)(1) A health insurer shall not, by contract, written policy, or written
17 procedure, require that a pharmacy designated by the health insurer dispense a
18 medication directly to a health care setting for a health care professional to
19 administer to a patient.
20 (2)(A) A health insurer may enter into an agreement with a health care
21 professional under which a pharmacy designated by the health insurer

1 dispenses one or more medications for a specific patient directly to a health
2 care setting for the health care professional to administer to the patient.
3 (B) A health insurer that enters into an agreement pursuant to this
4 subdivision (2) shall attest to the Department of Financial Regulation, in a
5 form and manner determined by the Department, that:
6 (i) the health insurer provides an expedited, patient-specific
7 exception process for cases in which a health care professional certifies that it
8 is unsafe for an individual patient's medication to come directly from the
9 health insurer-designated pharmacy;
10 (ii) the health insurer-designated pharmacy provides for same-day
11 delivery of medications from the health insurer-designated pharmacy to the
12 health care setting;
13 (iii) the health insurer-designated pharmacy is accredited by a
14 national pharmacy accreditation organization;
15 (iv) the health insurer-designated pharmacy has the ability to
16 deliver medications to the health care setting in a clinically appropriate dosage
17 and in a ready-to-administer form;
18 (v) the health insurer-designated pharmacy utilizes cold chain
19 logistics or other means to ensure that each medication remains at the
20 appropriate temperature through all stages of supply, storage, and delivery;

1 (vi) the health insurer-designated pharmacy provides a
2 medication's pedigree to certify to the health care professional that the
3 medication was handled appropriately throughout the supply chain;
4 (vii) the health insurer-designated pharmacy demonstrates
5 expertise and reliability in risk evaluation and mitigation strategy that comply
6 with U.S. Food and Drug Administration reporting requirements;
7 (viii) the health insurer or the health insurer-designated pharmacy,
8 or both, make access to a pharmacist available 24 hours per day, seven days
9 per week; and
10 (ix) the health insurer offers payment policies that reimburse for
11 office-administered medications at the same rates, regardless of whether the
12 medications were obtained from a pharmacy designated by the insurer or by
13 the health care professional or health care setting, which payment shall include
14 the costs for the health care professional or health care setting to intake, store,
15 compound, and dispose of the medications.
16 (d) A health insurer shall not, by contract, written policy, or written
17 procedure, require:
18 (1) sterile compounding by a health care professional in a health care
19 setting without providing reimbursement to the health care professional for that
20 service; or

1 (2) a medication with a patient-specific dosage requirement to be based
2 on lab or test results on the day of the patient visit to be distributed from a
3 health insurer-designated pharmacy to a health care setting for administration.
4 (e) A health insurer may offer coverage for, but shall not require the use of:
5 (1) a home-infusion pharmacy to dispense sterile intravenous drugs
6 prescribed by a treating health care professional to a patient in the patient's
7 home; or
8 (2) an infusion site other than the treating health care professional's
9 office or a hospital or clinic at which the health care professional practices.
10 Sec. 4b. 18 V.S.A. chapter 91, subchapter 5 is added to read:
11 Subchapter 5. Preferential Drug Pricing
12 § 4671. INTERFERENCE WITH PREFERENTIAL DRUG PRICING
13 PROGRAMS PROHIBITED
14 (a) A hospital or health clinic in this State that is entitled to preferential
15 pricing on outpatient prescription drugs under federal or State law or by
16 contract may purchase such drugs at preferential prices and arrange for their
17 shipment to a duly licensed pharmacy under contract with the hospital or clinic
18 for purposes of dispensing the drugs on the hospital's or clinic's behalf.
19 (b) No manufacturer or supplier of outpatient prescription drugs for which
20 a hospital or health clinic in this State is entitled to preferential pricing under
21 federal or State law or by contract shall deny shipment of such drugs to the

1 hospital's or clinic's contract pharmacy or place conditions or restrictions on
2 the sale of the drugs.
3 Sec. 5. DEPARTMENT OF FINANCIAL REGULATION; PHARMACY
4 BENEFIT MANAGEMENT; REPORT
5 (a) The Department of Financial Regulation, in consultation with interested
6 stakeholders, shall consider:
7 (1) whether pharmacy benefit managers should be required to be
8 licensed to operate in this State;
9 (2) whether pharmacy benefit managers should be prohibited from
10 conducting or participating in spread pricing;
11 (3) the cost impacts of pharmacy benefit manager licensure and related
12 regulatory measures in other states that have enacted such legislation;
13 (4) in collaboration with the Board of Pharmacy, whether any
14 amendments to the Board's rules are needed to reflect necessary distinctions or
15 appropriate limitations on pharmacist scope of practice;
16 (5) whether there should be a minimum dispensing fee that pharmacy
17 benefit managers and health insurers must pay to pharmacies and pharmacists
18 for dispensing prescription drugs;
19 (6) how a pharmacy should be reimbursed for a claim if a pharmacy
20 benefit manager denies a pharmacy's appeal in whole or in part, including
21 whether the pharmacy should be allowed to submit a claim to the health insurer

1 for the balance between the pharmacy benefit manager's reimbursement and
2 the pharmacy's reasonable acquisition cost plus a dispensing fee;
3 (7) whether there is a problem in Vermont of pharmacies soliciting
4 health insurance plan beneficiaries directly to market the pharmacy's services
5 and, if so, how best to address the problem; and
6 (8) other issues relating to pharmacy benefit management and its effects
7 on Vermonters, on pharmacies and pharmacists, and on health insurance in this
8 State.
9 (b) On or before January 15, 2023, the Department of Financial Regulation
10 shall provide its findings and recommendations regarding the issues described
11 in subsection (a) of this section to the House Committee on Health Care and
12 the Senate Committees on Health and Welfare and on Finance.
13 Sec. 6. APPLICABILITY
14 (a) The provisions of Sec. 2 of this act (18 V.S.A. chapter 221, subchapter
15 9, pharmacy benefit managers) shall apply to a contract or health plan issued,
16 offered, renewed, recredentialed, amended, or extended on or after the
17 effective date of this act, including any health insurer that performs claims
18 processing or other prescription drug or device services through a third party.
19 (b) A person doing business in this State as a pharmacy benefit manager on
20 or before the effective date of this act shall have six months following the

1 effective date of this act to come into compliance with the provisions of Sec. 2
2 of this act (18 V.S.A. chapter 221, subchapter 9, pharmacy benefit managers).
3 Sec. 7. 2021 Acts and Resolves No. 74, Sec. E.227.2 is amended to read:
4 Sec. E.227.2 REPEAL
5 18 V.S.A. § 9473~~(d)~~(g) (pharmacy benefit managers; 340B entities) is
6 repealed on ~~January 1, 2023~~ April 1, 2024.
7 Sec. 8. EFFECTIVE DATES
8 This act shall take effect on July 1, 2022, except that Sec. 4, 8 V.S.A.
9 § 4089j, shall take effect on January 1, 2023.
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17 (Committee vote: ___________)
18 _______________________
19 Senator _________________
20 FOR THE COMMITTEE