State of Vermont
Office of the Secretary of State

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James C. Condos, Secretary of State
Christopher D. Winters, Deputy Secretary
S. Lauren Hibbert, Director

To: Hon. Ginny Lyons, Chair, Senate Committee on Health & Welfare
From: S. Lauren Hibbert, Director of Professional Regulation;
Carrie Phillips, MS, PharmD, Executive Director, Board of Pharmacy
Date: April 13, 2022
Re:

It is understood that the Committee is considering an amendment of H.353, *An act relating to pharmacy benefit management*, to include aspects of S.242, *An act relating to prescription drugs dispensed by a health insurer designated pharmacy for administration to a patient in a health care setting*.

The following markup illustrates how salient language from S.242 could be merged into Sec. 4 to more effectively restrain white-bagging and brown-bagging.

Sec. 4. 8 V.S.A. § 4089j is amended to read:
§ 4089j. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS

* * *

(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 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.

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

(3) A health insurer or pharmacy benefit manager shall adhere to the definitions of prescription drugs and the requirements and guidance regarding the pharmacy profession established by State and federal law and the Vermont Board of Pharmacy and shall not establish classifications of or distinctions between prescription drugs, impose penalties on prescription drug claims, attempt to dictate the behavior of pharmacies or pharmacists, or place restrictions on pharmacies or pharmacists that are more restrictive than or inconsistent with State or federal law or with rules adopted or guidance provided by the Board of Pharmacy.

(4) A health insurer shall not, by contract, written policy, or written procedure, require that a pharmacy designated by the health insurer dispense a medication directly to a patient with the expectation or intention that the patient will transport the medication to a health care setting for administration by a health care professional.

(5) A health insurer shall not, by contract, written policy, or written procedure, require that a pharmacy designated by the health insurer dispense a medication directly to a health care setting for a health care professional to administer to a patient.

~~(4)~~(6) The provisions of this subsection shall not apply to Medicaid.

Stakeholders may wish to retain the flexibility associated with other sections of S.242. The Office would not find the inclusion of that language objectionable and considers the question a policy choice for the Committee.

We do, however, strongly recommend that H.353 avoid reifying the concept of "specialty pharmacy" or recognizing in law special, non-governmental pharmacy accreditations. Industry has on occasion employed private pharmacy accreditations as a pretext to restrain consumer choice. For this reason, requiring certification to DFR, for example, that "the health insurer-designated pharmacy is accredited by a national pharmacy accreditation organization," or that "the health insurer-designated pharmacy is accredited by a national pharmacy accreditation organization," would tend to undermine the legislative purpose of the bill. The Office recommends not including language that further creates the concept of "specialty pharmacy."

Thank you for the opportunity to weigh into these important bills.